TRANSCRIPT PREPARED BY THE CLERK OF THE LEGISLATURE
Transcriber's Office

COMMITTEE ON HEALTH AND HUMAN SERVICES
February 16, 2005
LB 318, 381, 382, 712, 725

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 16, 2005, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB 318, LB 381, LB 382, LB 712, and LB 725. Senators present: Jim Jensen, Chairperson; Dennis Byars, Vice Chairperson; Doug Cunningham; Philip Erdman; Gwen Howard; Joel Johnson; and Arnie Stuthman. Senators absent: None.

SENATOR JENSEN: Good afternoon, ladies and gentlemen. Welcome to the Health and Human Services Committee hearing. Today we have one, two, three, four, five bills, and we also have with us Fred Schuster who is from Kansas City who is with the Medicaid/Medicare service and to go over a few things with this committee and with the state on the issues that are before him. I do want to make mention while we're all together here that there is a table over here to my right, your left, and there are sheets over there, testifying sheets. And so if you are going to testify on a bill a little later, please pick up one of those now and as you come forward you place that sheet into the box and you give us your name, spell your last name for us so that we have it proper on our transcription. These proceedings are transcribed; they're recorded. If you are carrying a cell phone, I would urge you to shut off the ringer so it doesn't go off in the transcriber's ears. And then also tell us if you are representing yourself, if you are representing an association, and then we'll proceed. We do take proponent testimony first, opponent testimony second, and neutral testimony if there is any. I will introduce you briefly to the senators that are here. Senator Phil Erdman who is from the Bayard area way out west; next to him is Senator Doug Cunningham who is from Wausa, Nebraska; next to him is Senator Dennis Byars who is Vice Chairman of the committee and he's from Beatrice, a little bit south of here; to my right is Jeffery Santema who is the committee counsel; I'm Jim Jensen from Omaha, serving as Chairman; to my left is Joan Warner who is our committee clerk; next to her is Joel Johnson who is senator from Kearney; and then Arnie Stuthman who is from Platte Center; and Senator Howard who is from the Omaha area. I might mention we have Jill as a page. If you are going to give us any papers, the correct number is about 12, but if you don't have that many we could

make copies. Also next to Jill is a young lady from Lincoln Southeast who has been shadowing me this morning and we're very happy to have her here too. With that, welcome, Fred, and it's sure good to see you again.

Presentation by Region VII Office
United States Department of Health and Human Services

FRED SCHUSTER: Mr. Chairman, thank you. I appreciate the opportunity to be here again today. Part of my duties is to serve as a liaison with state, local, tribal governments and the departments. And I think in order to be successfully in those duties I need to take the first step, so this is my third annual official trip to Lincoln, although I do get to Nebraska a lot more than just once a year. As the committee knows, I was here last week for a presentation on community health centers but I was also up a ways on 27th Street doing a Medicare presentation opening comments there. I believe communications are important throughout the year. HHS needs to know of your interest, your concerns, and you need to know what we do and what we can do. So this is especially important because of term limits. And I want to bring as many federal dollars that we can, that you want, back to the region. But in order to do that we need to continue an open line of communications. Today I've got several very knowledgeable regional folks with me and they're all going to say a few words, one or two minutes, and then we'll take...we'll try to answer whatever questions you have. Many of these folks that will be speaking really excel in what they're doing, all of them do. Many of them have spoken or worked out in their central office so they are keenly aware not only of things here but also nationally. Now I don't want to overpromise anything but I can promise you that we want to work with you and that we want to do everything we can to help and answer your questions and contact central office to push things through or to get your questions answered. So we're going to start with Pat Brown, and I just ask you all to come up here, sit in this chair so that the transcriber can hear you.

SENATOR JENSEN: Welcome, Pat.

PAT BROWN: Good afternoon. I'm Pat Brown with the

Administration for Children and Families with Health and Human Services. And I have responsibility for all of the state, community, and tribal programs. This includes child welfare, childcare, child support, TANF, developmental disabilities, Headstart, and youth. If there are any particular questions you have I'll be happy to answer them. We're really proud of some areas that Nebraska is moving forward in, particularly in the area of child support. Nebraska has received over $3 million in incentive funds. The office that you've opened with Iowa has become a national model in other states. They're really asking about that particular model in terms of serving interstate cases. And Iowa has already seen $20,000 to $30,000 more collection each month. I don't know what the figures are for Nebraska yet; I haven't received that but it's very promising. In TANF, you've received...you are ranked fourth in the nation for your workforce rating in terms of job entry and retention and earnings, so that's a really good thing. In child welfare, we were hoping for some change and we're seeing some promise in some of the things that you've been doing in the area of accountability in terms of beefing up your child welfare safety issues related to child abuse/neglect investigation. So there are a number of things I could talk about. If there are particular questions that you have related to the programs that I'm responsible for, I would be happy to answer those now or later or whenever you want to do that.

SENATOR JENSEN: Okay, real good. Any questions at this moment for Ms. Brown? Yes.

SENATOR BYARS: Thank you, and I won't force you into a lot of detail, but we have a number of individuals with developmental disabilities in this state, and this Legislature has always been very aware of them and very supportive of those individuals with state programs in partnership with the federal government.

PAT BROWN: Um-hum.

SENATOR BYARS: So I look at some of the President's suggestions in his Medicaid reform piece. I'm somewhat concerned in the several areas where we're going to be going with that piece. One being vocational rehabilitation and

some of the cuts in those programs. Many of the individuals we, as the state, have been trying to empower to move into these programs to work their way into employment to enable them through special devices, as well as special training, to be able to work and then enable them to give them bridges to stay in that area. Also in IDEA, which, of course, has never been fully funded, Senator Hagel has pushed very hard to try to get additional funding. We're way underfunded in this state which puts a tremendous amount of pressure on us as a state and our educational system. So if you would like to comment on those I would like to hear your comments.

PAT BROWN: I think most of...even though we have responsibility for the DD program, most of the services under DD are funded through CMS. We get funding for the infrastructure, for planning, for protection and advocacy issues but not actually the funding of the service. The community based services and those kinds of things, I think Nan probably and Tom can talk about that later. In terms of IDEA, I don's have any additional information about how much...if any more dollars are going to be put in that so that more can be done, but I'll take your concern back and try to figure out if there is something about funding that I don't know about. But I haven't seen any increase.

SENATOR BYARS: Okay. Also does your division deal with the dually diagnosed with dual eligibles?

PAT BROWN: Well, the DD network does, but we don't service...we don't provide services for the actual families that are involved or the individuals that are involved.

SENATOR BYARS: Okay, thank you.

PAT BROWN: That's through CMS.

SENATOR JENSEN: Anything else? Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Pat, your reference to child welfare and...or abuse and neglect, are we going in the right direction? We're trying to be more accountable on the state level or is there something that we could be doing in addition to that to try to improve our system?

PAT BROWN: I think you're doing very well in the areas of safety. As you know, we did a child and family service review here about two years ago, and the state entered into, with the federal government, a program improvement plan. You're about 16 months into that plan and have been meeting the targets that you have set, and so I think you're moving forward. I think with the addition of the workers that you hired, I think there are still a few more that you need to hire. I think the biggest need is not really in the safety area, but in terms of looking at improving permanency issues for kids in the area of adoption, in the area of reunification of children with their families within the first year that they come into the system. Those are the areas we need to see the most improvement in.

SENATOR STUTHMAN: Okay, thank you.

SENATOR JENSEN: Yes, Senator Howard.

SENATOR HOWARD: It is as if you could read my mind--the areas of permanency; exactly. I was going to ask if you were seeing or could anticipate increased funding in the areas of permanence in adoption and other resolutions for permanency for children. What do you anticipate will be coming?

PAT BROWN: I don't think we'll get any increase in funding. And as you know, 4E doesn't actually pay for services. It actually pays for maintenance, adoption assistance, and administrative costs. But I think the budget is pretty flatline in terms of child welfare dollars and the only way the state really can get more child welfare dollars is if the penetration rate in foster care would go up. Nebraska's penetration rate is pretty low, around 22 percent. And I don't know of any others in which we anticipate an increase in monies in child welfare.

SENATOR HOWARD: Do you see anything in terms of preventative services? It's always been an area that...I come from Health and Human Services, from being a case manager and an adoption worker. Preventative services have always been a difficult thing for us to get a handle on because we're putting dollars into the other end.

PAT BROWN: Um-hum.

SENATOR HOWARD: Do you anticipate anything that will be of assistance in that area?

PAT BROWN: I haven't seen anything beyond the community services funding that the state gets, CAPTA funding, and that is an area...I agree, too, that if we do a lot more in preventative we can keep kids out of foster care. I think some states are looking at using some of these 4E dollars for preventative things. If children are actually candidates for foster care then you can use some of your 4E dollars for actually providing for those kids.

SENATOR HOWARD: It's to target those kids.

PAT BROWN: Right, to serve those kids. If you can show that those children are potential candidates for foster care; if we did not provide these services to them they would more than likely end up in foster care.

SENATOR HOWARD: Could we prove the eligibility prior to entering the system though?

PAT BROWN: Excuse me?

SENATOR HOWARD: Could be prove the eligibility prior to entering the system?

PAT BROWN: Yes. Yes, you would just have to show absent these particular services these children would more than likely enter foster care.

SENATOR HOWARD: Thank you.

PAT BROWN: Document it through a case plan.

SENATOR HOWARD: Thank you. Great.

SENATOR JENSEN: Any other questions? Thank you very much, Pat.

PAT BROWN: Okay.

DIANE CASSITY: Hi, my name is Diane Cassity and I'm with the Department of Health and Human Services Office of Public Health and Science. Our office works with states and community based organizations on issues relating to minority health, women's health, reproductive health, HIV and AIDS, and emergency preparedness. And our priorities are elimination of health disparities, cardiovascular disease. Recently we had Red Dress Friday and I think Nebraska observed that, to to promote awareness of women's health and cardiovascular disease. And other priorities are diabetes and fitness. The new dietary guidelines have been issued just recently. With that goes obesity prevention and activities such as that. As it relates to emergency preparedness, I want to express my appreciation to Nebraska and their leadership in the area of mutual aid among states. Your health officer, Dr. Raymond, has really shown some leadership in that area and the states in our region, the four states in our region and the adjoining region, Region VIII out west have made progress in working together to improve cooperation to better serve issues relating to emergencies.

SENATOR JENSEN: Great. I am from Omaha, which is Douglas County. Douglas County has twice the number, the national number of individuals with STDs.

DIANE CASSITY: Um-hum.

SENATOR JENSEN: Twice the national average. And as a matter of fact, of that number 67 percent of that number are blacks from the age of 13 to 24. So we really have a problem, almost epidemic problem in that area. Are there any funds that are available that could help that community? Also, as you know, AIDS is...with STDs you have a five times greater chance of developing AIDS; you don't get AIDS from STDs but you get AIDS from the same activity that you get STDs. And so it's really a concern to me and of my community of how we can deal with this. Now I have met with some black leaders and will again on Friday who are trying to do mentoring programs and whatnot, but is there anything else that would be available to help us in that area?

DIANE CASSITY: Yes, there is. There is a program that our

office oversees that is funded by minority health to increase capacity among minority communities for small community based organizations to receive small grant funds to improve services and resources for minority HIV/AIDS and prevention, so yes.

SENATOR JENSEN: We have a very good FQHC in that area, so they could probably, I would think, administer that and they are doing certainly some testing. Or would that be available?

DIANE CASSITY: This is more, really community based and grassroots, so it's not available to organizations that have a budget I believe of $100,000 or more, so this is more of a grassroots program. But another federal agency the Health Resources and Services Administration does administer a number of HIV and AIDS service projects that that federally qualified health center would qualify for.

SENATOR JENSEN: Okay. Good, appreciate that very much. Any other questions? Yes, Senator Johnson.

SENATOR JOHNSON: Along this line, I'm big into prevention as opposed to cure. What works the best for prevention of the type of problems that Senator Jensen has been talking about?

DIANE CASSITY: I think education is really the most important thing. First of all, prevention to let people know that the safest way to prevent STDs and AIDS is through monogamous relationships in marriage and celibacy or... And so that's the most important prevention approach. And if that's not something that works in the community, then use of condoms.

SENATOR JOHNSON: Let's assume it doesn't.

DIANE CASSITY: Use of...the...there's an A-B-C approach with the...that is used by the department, and that's abstinence, be faithful, and condoms is C, so condom use.

SENATOR JOHNSON: Okay, what was B?

DIANE CASSITY: Pardon?

SENATOR JOHNSON: What was B?

DIANE CASSITY: Be faithful. Be in a monogamous, faithful relationship.

SENATOR JOHNSON: But, see, I'm trying to eliminate to me that is a very nice goal to talk about that all of us would aspire to, but is it realistic?

DIANE CASSITY: Well, that's why we have the C, the condoms.

SENATOR JOHNSON: And so do we need to concentrate on the things that are realistic rather than what, in a sense, religiously or morally, some of us might think is the best?

DIANE CASSITY: I think that we need to have all of these approaches, including the preventions.

SENATOR JOHNSON: I want to know what works.

DIANE CASSITY: They all work. They all work, and different approaches work with different communities, so.

SENATOR JOHNSON: And that's what I...but, see, you're getting back...which community does which work in? If you go to a church group in Kearney, Nebraska, one thing might work there and another might not. And so...what I'm trying to do is to fit the type of program that would fit which with each area.

DIANE CASSITY: And our...the small community based grant program that we have does work with local community organizations and helps them develop programs that will fit their community.

SENATOR JENSEN: Any other questions from anyone?

FRED SCHUSTER: Do you need a contact for that agency?

SENATOR JOHNSON: No, no. I just...I want to know the philosophy of where you are going with this because I get the sense that we have, as a nation, tried to take what might work well in Kearney, Nebraska, but might not work in

another community and that we kind of stick with that. Now, maybe that's just sense of things. But certainly I have that sense that we don't apply kind of altruistic goals to places that maybe those are not the most effective tool.

FRED SCHUSTER: Did Diane help clear that up?

SENATOR JOHNSON: No.

FRED SCHUSTER: No.

SENATOR JOHNSON: But let's go on.

FRED SCHUSTER: Can you talk maybe to Senator Johnson more or should we...anymore information?

SENATOR JOHNSON: I would be glad to if we can.

SENATOR JENSEN: Anything else of...? Thank you, Diane.

RICHARD PENDLETON: Good afternoon.

SENATOR JENSEN: Hi.

RICHARD PENDLETON: My name is Richard Pendleton. I'm the director of compliance for the Food and Drug Administration District Office located in Lenexa, Kansas. Our office in that location works in the states of Iowa, Nebraska, Kansas, and Missouri, and we have several resident offices spaced throughout those states, including one in Omaha with three investigators located there. We, of course, do a lot of inspectional work in these four states and we must rely on our partners in these states to help us in these areas. So we do a lot of contracting with both your Departments of Agriculture and Health to assist us in meeting our goals with the inspectional priorities that we have in the areas of food manufacturing, medicated feeds, and so forth. BSE continues to be a main concern, BSE and mad cow disease, and that's one of our top priorities to cover every year. We do our best to do a 100 percent coverage of all feed mills, medicated feed mills and facilities that render products from carcasses, and so forth. And so we really must rely on our state partners to assist us in us because we just don't have the manpower to cover all the industry that is our

there. And as far as Nebraska goes with the Department of Agriculture, we contract with them every year to do over 200 inspections in these areas. And they have been of tremendous assistance to us in meeting the demands that have been put on us to make sure that we cover that industry. And to date we have not found any problems that we need to concern ourselves with in our area. We do know that there has been a couple of isolated incidences pop up from animals that have originated in Canada. But fortunately this area has been spared. And it's our obligation to make sure that it stays that way. We work hand-in-hand with the USDA on this at all times. So we genuinely feel that the work that we get from our partners in these states is a tremendous benefit to the entire agency and certainly to the citizens of the state. There is certainly a lot of other things going on with Food and Drug right now. Certainly have been in the news lately on a lot of issues with drug safety, on Vioxx and so forth. And I see that on the news last night that they have just appointed an independent counsel outside of the agency to take a look at the safety of these drugs to determine if they should remain on the market or not. At this level in the district we don't really get involved too much in those matters; they are more on the top levels back in Washington, D.C. That's roughly about it.

SENATOR JENSEN: Okay. Thank you. Any questions of Richard? If you need to visit with the Ag Secretary, please give us a call. We'll see if we can arrange that.

RICHARD PENDLETON: Certainly, okay. There's no questions on drug programs or anything?

SENATOR JENSEN: No. Are there any more questions?

RICHARD PENDLETON: Okay.

SENATOR JENSEN: Thank you very much for coming.

RICHARD PENDLETON: Thank you very much.

LARRY BREWSTER: Mr. Chairman, members of the committee, my name is Larry Brewster. I'm the regional administrator for the U.S. Administration on Aging. The Administration on Aging is responsible for administering the Older Americans

Act which is the federal statute that deals with federal programs of services and grants to state and local agencies on aging for serving older persons. You may recognize the funding that we provide to the state as the funding that keeps the nutrition program in your community operating or the transportation program and other social services that are delivered through area agencies on aging and the agencies that they contract with. We provide funding to the state on a formula grant based on the number of older individuals in your state as a proportion to the national population. So Nebraska receives its money based on census data of older persons. We also, in addition to the formula grant that we provide to the state, we also administer the national longterm care ombudsman program which is administered through the state Agency on Aging here in Nebraska. We have three priorities that we are really focusing on at the national level and we are working with the states on these priorities. First is health promotion and disease prevention, and we are in the middle of a national campaign which is called the You Can! campaign, which is designed to improve the nutrition and to increase the amount of exercise that older persons have because of the finding that there is a relationship between good nutrition, increased exercise, and good health. I am pleased that the state agency here in Nebraska is one of our partners in promoting the You Can! campaign, so we're pleased with that. Our second priority is to support family caregivers in their efforts to keep their older relatives in their home and to prevent premature institutionalization. We provide funding to the state in the form of a grant that assists the state to develop a program to support caregivers. And, finally, we are promoting and strengthening the home and community based service programs within states. We recently initiated a nationwide discretionary grant program in cooperation with the Centers for Medicare and Medicaid Services to develop what we are calling aging and disability resource centers. Nebraska does not have one of those discretionary grants. So far we have funded 24 states and we hope to fund 50 states. The purpose of the aging and disability resource center is to provide a focal point in communities where families and individuals that need assistance in looking at resources that can assist them to stay in the community can go and can get information about those resources and can also get

assistance in accessing those resources. And the final point I'd like to make is that this year in October is going to be the holding of the 2005 White House Conference on Aging. It's an opportunity for individuals from across the nation to come together to talk about issues facing older Americans and to come up with recommendations that will be given to the administration and be give to Congress in terms of directions that the federal government needs to take in terms of policies. This is a critical year because as you are aware within the next ten years the baby boomers will be joining us as seniors. And so it's critical that we really take a look at those recommendations, so it's very timely. And with that, Mr. Chairman, I'll take any questions.

SENATOR JENSEN: Great. Yes, Senator Stuthman has a question.

SENATOR STUTHMAN: Thank you, Senator Jensen. Larry, you mentioned about supporting community based services. Have you got any program or any type of a grant program that would be for the mental health part of it, community based mental health?

LARRY BREWSTER: Senator, no we do not provide grants to states for mental health type services. That would have to come through SAMHSA.

SENATOR STUTHMAN: Okay, thank you.

SENATOR JENSEN: Any other questions? My wife was a par of that area, or the aging group back in Washington a few years ago. Very much enjoyed it and got a lot of great information,...

LARRY BREWSTER: Great.

SENATOR JENSEN: ...so I can highly recommend that.

LARRY BREWSTER: Good. Thank you.

TOM LENZ: Good afternoon, Senator Jensen. Good to see you again.

SENATOR JENSEN: Good afternoon. Good to see you again.

TOM LENZ: I am Tom Lenz and I'm the acting regional administrator for the Centers for Medicare and Medicaid Services. And our agency is responsible for the federal administration of four general programs and I'd like to touch on each one of them. And Nan Foster Reilly, our associate regional administrator for the Medicare side of our programs is here to pick up some important work also. The first area I would like to touch base on is our quality assurance work that we do. The state, under contract with CMS, provides quality assurance surveys of the nursing facilities and hospitals that provide services to the Medicare and Medicaid beneficiaries and all beneficiaries, residents of the state. As part of being a certified provider, you are expected to provide an expected level of care, and the state, under contract with the federal government, does those surveys to assure that level of care is being achieved. Our office provides oversight of that process and to assure that the federal standards are complied with. The one thing that I know that is happening in a little different...somewhat differently than in the past is in the area of life safety code surveys. That aspect of the survey looks at the safety, the heating plant, the physical plant, the fire safety standards, and those types of things. We were criticized by the General Accounting Office for not being aggressive in following up in states' activities in this area or surveys in this area. A new expectation has been put on CMS so we will be doing far more oversight surveys of your state survey activities this year. It will be an increased emphasis. The second area is the quality improvement of healthcare. And here we have a division that works with the quality improvement organizations within each of the states to work with hospitals and provider groups to improve the quality of care that's provided to the residents of the state of Nebraska. The third area is the Medicaid program. And the Medicaid program is, as you well know, in partnerships with the federal government, we provide a whole range of services to the aged, blind, and disabled, and the less fortunate in the state. The major areas that we have of emphasis in this particular program continue, as like I indicated last year, enhanced financial management oversight. We have hired an additional group of auditors and have assigned those to each state in the nation so there is going to be heightened

presence in the state of Nebraska. Now, while that may raise some concern, our experience is I think we've pretty well, and what I've looked at we've looked at most of the stuff where the state of Nebraska could have leveraged additional federal dollars inappropriately. And I believe Nebraska...I don't want to give you a complete pass, but I'm not overly concerned that there are gigantic federal disallowances in the wings in Nebraska. The issue we had we school based services to a long time and I think we've released the money on school based services at this point in time. We're just waiting for some final documentation to clean up some last questions that the...you had an upper payment limit state plan amendment and I believe we worked through that. And there was an intergovernmental transfer program and I believe we're getting real close to working through those issues. So while you will see that heightened oversight, and we will...if an issue arises, we will be more than happy to work with you as aggressively as we can to resolve those issues as they come up. The administration at this point is working on a prospective basis on most of those significant financial issues. If they come up, find a problem, they've been actually looking to get those corrected prospectively and move forward. The third area is the Medicare side of the Medicare program. And here we have the most significant piece of legislation since the enactment of the program in 1965, the new Medicare drug benefit that's going to go into effect on January 1, 2006. This is going to have a significant impact on the state of Nebraska. I believe the state of Nebraska has 257,000 Medicare beneficiaries. And each one of those beneficiaries will now have an opportunity to have some form of drug coverage. They can continue under their current plan if they have an employer provided plan, if they are a retiree and have an employer provided plan. They can participate in the Part D benefit. The Medicaid beneficiaries will, if they are dual...full dual benefit-eligible individuals...their benefit for drugs will be through the Part D benefit rather than the state. And then there is, you know,...and I...the phasedown I think is the proper term we use rather than the "clawback" to have the state make sure that the federal government doesn't absorb an undue share of that portion of the expenditure. There will be extra help in this benefit for those that meet certain income guidelines. And so the subsidy...there will

be a low income subsidy. We're working very aggressively with the Social Security Administration to make sure that that subsidy is implemented in the easiest way possible. It's going to be a difficult outreach to make sure that every beneficiary has an opportunity to understand the program and the options that are available to them to receive coverage. And we really look for your support and help in getting that education campaign out to the beneficiaries because it does translate into a direct benefit to those individuals that are not receiving the drugs because they can't afford it, that they really need. So with that quick overview, Nan, do you have anything else to add or...?

NAN FOSTER REILLY: I only wanted to make sure that the committee is aware of a couple of aspects of the Medicare Modernization Act. As Tom said, it is one of the most significant changes to the program since its enactment. In addition to the drug benefit that will be available next year, starting in January of this year, last month, Medicare beneficiaries will be able to receive some new preventive benefits, as well. You are probably well aware that the Medicare program was not instituted with a lot of preventive benefits in it. There are a number of preventive benefits in the Medicare program that have been put in over time and this year with the Medicare Modernization Act three new preventive benefits were started. There is a "Welcome to Medicare" physical that every Medicare beneficiary within the first six months of coming onto the program will be able to have reimbursed. There are also new screenings for diabetes and for cardiovascular disease. So there are some very significant improvements to the program in addition to the drug benefit that Tom mentioned. With regard to the drug benefit and the very important work we will do to try to educate and make sure that all 250,000-plus Medicare beneficiaries in the state of Nebraska are well educated, well informed, and make a conscious and informed decision, a very important insurance decision. We will be working with a number of community based organizations and other partners in the state of Nebraska as well as our other states. We will be working the Administration on Aging and their grantees, as Mr. Brewster just made reference to. Those grantees are in your communities and are a wonderful resource for us in educating those beneficiaries. The state

health insurance counseling program which is run out of your Department of Insurance is a fine partner for us in reaching out to Medicare beneficiaries to educate them. Their grant runs about a quarter of a million dollars this past year. And we see continued support for the SHIIP programs in terms of funding through grants from the Centers for Medicare and Medicaid Services. So they are also a very important partner. This past week we had a conference in Lincoln for community based organizations and providers attempting to reach out to every organization we possibly can that touches Nebraskans who are on Medicare so that we can make sure that they have the very best information about this new benefit. We'll be doing an event in western Nebraska next month in the Sidney area to make sure that we have both listened to providers in that area about concerns rural providers may have, but also to reach out to community based organizations in that area as well. So I wanted to make sure that you were aware not only of the benefit but of some of the very important work being done with our agency and by Nebraskans to make sure that Medicare beneficiaries in Nebraska are well informed. Thank you.

SENATOR JENSEN: Thank you. I happened to be visiting with a director of AARP and asked him what percentage of their individuals had signed up, and he said about 15 percent. Is that about what you are seeing across the states? We've had a little higher than that, I think, throughout our system.

NAN FOSTER REILLY: Are you talking about signing up for the drug card that was in place this year?

SENATOR JENSEN: Yes. Right.

NAN FOSTER REILLY: I think the numbers may be a little bit higher than that, than that percentage. But that...the drug card, as you will remember, was an interim step, something that CMS could do right away as soon the Medicare Modernization Act was passed, to try to provide a little bit of help and some discounts for those that don't already have decent drug coverage while we did the work of implementing a very good drug benefit next year. So I don't know that there would be a comparison between the drug card participation rates and the drug benefit participation rates. The benefit is a very different kind of thing than

the drug discount card. Although the drug discount card did provide a lot of good help to some people, it wasn't necessarily for everyone. But the drug benefit will be a significant subsidy for Medicare beneficiaries in covering their drugs, not just discounts.

FRED SCHUSTER: I might also say that I think there had been a lot of information...misinformation about the drug card. As Nan said that not everyone could benefit from it as well as maybe others, but some would say, well, my income is too high. And what they were referring to was it was too high to qualify for the $600 credit which is 135 percent of poverty. But 135 percent of poverty does not disqualify you for the drug card. It disqualifies you if you...for the $600 credit. And so I made numerous presentations, almost 100 of them, and that was something I ran into constantly and I think Nan, and you probably would say the same thing, that people...it was just a misinformation campaign there for awhile about that.

NAN FOSTER REILLY: And I'd also like to add that our experience in doing outreach around the drug card has been very instructive for us as we move forward in doing outreach around the drug benefit. One of the things that we will make sure that we stress from the outset is that this drug benefit is available to every Medicare beneficiary. There is sometimes a misunderstanding that it is only available for low income Medicare beneficiaries. There is extra help with premiums and copays for those beneficiaries, but every one of the 41 million beneficiaries in this country will be able to avail themselves of that drug benefit.

SENATOR JENSEN: And should sign up.

TOM LENZ: Yes, that's...they should evaluate it.

FRED SCHUSTER: It is optional, again, if they don't want to for whatever reason.

NAN FOSTER REILLY: It is a choice.

SENATOR JENSEN: Sure. Senator Byars had a question.

SENATOR BYARS: Oh, I probably have a hundred, but we don't

have time to do that. But I spent the weekend with a task force, the National Conference for State Legislators is convened dealing with the Medicaid and Medicare issues and Winnie Pizzano was there spending the weekend with us. So I was able to get a lot of these questions answered, but I found among my colleagues from across the country, from the northeast to the southwest to the west, that we were having a hard time grasping all of Medicare Part B and it really concerns me about the information piece that are going to be put out to our senior population of those eligible. The one thing I will hope you will do and you will remember is to make sure people know the point of access and where they can go to get information, whether it's the Area Agency on Aging, whether it's the Social Security Administration which is a natural place for people to go, and pointing out the number of people who didn't access the interim piece points out, as you said, the need for education. Now, I know a letter is going to go out to everybody in an appropriate time but this is so important for all of us to partner and have that information to share. A lot of people aren't going to grasp all of the things that they have available to them as far as the options. IGT, I think it was our impression here in the state, at least it was mine from the information coming out of Washington, IGT was done, period, done, finished, completely down the drain. The secretary was through with it. And as I found out from Winnie, that's not the case. The secretary will be negotiating, will be talking with all of the governors of the states that have been receiving IGT funds and that there are options such as we have just been approved for in December on some IGT funds with using provider taxes for healthcare that are still going to be available to us.

TOM LENZ: For...no, they're to be sunset. They are going to be available for a specified period of time, and my understanding is and there is only one case that I know of nationally where that sunsetting time frame was beyond July 1, 2005. The administration has been very consistent on all the plans and everything that's been approved to date that the thought was we would give each of the state legislatures an opportunity to meet one more time and correct the what we believed was an inequity. And therefore most of those legislatures are meeting now, and the thought was at the start of their state fiscal year they should

correct that. Now, that's the message that I have consistently heard and I only know of one case where I think it may have been extended beyond that, but I'm not sure, so.

SENATOR BYARS: Okay. We need to get that straight. We need to understand because we have a situation here where we were approved in December for an application that we made to use provider tax for IGT funds which reaches out and our budget would be built on providing services to our ICFs with those dollars. And...

TOM LENZ: Now, the tax and the IGT is a different issue. The tax is one component and the intergovernmental transfer is another. You can have a valid tax with general applicability. Nursing facilities tax, I believe Nebraska came forward with a managed care tax also at one time. Now, if you meet the standards in our regulations regarding the general applicability of those taxes and there can't be a hold harmless and those types of things, we can approve that as a tax that's acceptable to the federal government, just like a general sales tax. And if that meets all the requirements, that can go on infinitum, you know, until you no longer meet the requirements.

SENATOR BYARS: Okay, and this again points out what we're talking about, IGT, provider tax, upper limit,...

TOM LENZ: Yeah.

SENATOR BYARS: ...all of those things that come into play here and we don't even understand all of those and we get mixed messages. So I hope our departments aren't going to leave money on the table, thinking that they aren't eligible.

TOM LENZ: I will say this, that our region has been very good about working with all of our states to make sure that we...and I'm going to use leverage...what dollars are appropriate for our states.

SENATOR BYARS: And you haven't seen anything, you looked, and you've looked at these pieces and you see nothing that we are...

TOM LENZ: That's exactly...that not inconsistent. And, in fact, I...we actually worked with the state of Nebraska to develop the upper payment limit state plan amendment. And I believe, you know, one of my predecessors actually testified in support of what the state was proposing. At that time it was legal, and as a result the state of Nebraska leveraged a significant amount of dollars through that program.

SENATOR BYARS: Yes, we did.

TOM LENZ: So we...we'll work with you but within the existing regulations and application of those regulations.

SENATOR BYARS: Yeah. Just as long as we know what to expect so budgetarially we know where to be relative to that issue rather than getting to July 1 and we've built into our budget these dollars that we're using to give increases to providers that haven't had any increases for four or five years,...

TOM LENZ: Um-hum.

SENATOR BYARS: ...and to be able to deal with that.

TOM LENZ: Let me touch briefly on it, Senator, on the concept of the intergovernmental transfer. Now that's a different one. Now that's where the total payment is made out to the provider...

SENATOR BYARS: Right.

TOM LENZ: ...and then an amount is given back to the state. And then that money is then used to leverage additional dollars. And, you know, on the surface it's a shell game, so, you know.

SENATOR BYARS: Yeah, we know. I know you know that.

TOM LENZ: And that's a different piece that is being addressed very...

SENATOR BYARS: Yeah, we were too late getting into that or we would have used that game, too.

TOM LENZ: Well, you used that, Senator. I helped personally with one that we set up...

SENATOR BYARS: Okay, we used it a little bit. (Laughter)

TOM LENZ: You used it a little bit.

SENATOR BYARS: Now is it true that the real choice grants which we've used for a lot of planning and...they're going away?

TOM LENZ: The real choice grants? Not to my knowledge.

SENATOR BYARS: That's what I was...

TOM LENZ: I will...

SENATOR BYARS: Will you check on that and let me know, please?

TOM LENZ: I will check on that. Was that part of the...? You know, I scanned the new budget, the President's budget, but...

SENATOR BYARS: I read that as one of the piece that was going away, but what do I know; I'm a senator.

TOM LENZ: That's been a successful...

SENATOR BYARS: Small mind. Thank you very much.

TOM LENZ: Okay.

SENATOR JENSEN: Any other questions? Senator Erdman.

SENATOR ERDMAN: Were you wearing your glasses when you were reading that?

SENATOR BYARS: Probably not.

SENATOR ERDMAN: Just a comment, and I was impressed when you said you were going to have a meeting in western Nebraska. To most Nebraskans that's Kearney, and as a representative of Sidney and actual western Nebraska I'm

appreciative of the fact that you are reaching out to all areas of the state. So thanks for your recognition that there is more than just half the state here.

NAN FOSTER REILLY: We are often trying to get our central office counterparts out to places like western Nebraska, and we were successful this last year in doing a rural preceptorship in western Nebraska. They thought rural was just outside of Lincoln at one point in time. So we're glad to be there; thank you.

SENATOR ERDMAN: Thank you.

SENATOR JENSEN: Senator Johnson.

SENATOR JOHNSON: Well, just one little bit of follow up of what Senator Byars said. You know, so far the drug program, you talk about education and so on of the public, and I guess that's my main concern because it almost took a Ph.D. to figure out the program that we've just been through. And I hope that we can do a little bit better with the more permanent program now so that you don't have to have the Ph.D. to figure it out.

TOM LENZ: I would strongly agree with that. My barometer for this is my 84-year-old mother. I took her to the Medicare Web site which is a great Web site and I said, Mom, let's go see if we can figure this out. And not surprisingly, she struggled. So frequently we're going to have to have that loved one to help them understand it. We have to have enough specificity, but the outreach activities and the education programs are being focus tested now and so we'll certainly make sure we get down to the level where they are understandable. We also want to make sure that we work with every possible entity within the state of Nebraska that can help us get the message out. We're developing a state-by-state strategy in this region to bring everybody into that effort because it's such an important piece of work that we've got to succeed in accomplishing. So we're going to look at faith based organizations and work with them, and, you know, our traditional state partners, as well as our other grantees. So it's going to be a very, very tough, long year.

SENATOR JENSEN: Great.

TOM LENZ: And January 1, I hope we're successful and everybody at least is educated on the benefit and understands the benefit and has made a conscious decision on whether they want to enroll in the benefit or not.

FRED SCHUSTER: Let me just add to that. Even 40 years ago, the original Medicare legislation is now about 40 years old and it's very complicated. I don't know of anyone that completely understands it but we don't want to do away with it. We can't imagine life without it. There are a lot of options, there are a lot of choices with this benefit, but it's also going to be a lot of help available. You've got the 1-800-Medicare number, you've got the state SHIIP offices that can help come out, so there will be a lot of help available to help people guide themselves through this.

TOM LENZ: And, again, touch base with our office. If you have any issue that comes up or have a thought on how we might be able to help, get the message out, call me directly or call Fred and he'll make sure that he gets the message to me.

SENATOR JOHNSON: My point is not...see, I want it so that you don't have to be that much help. I want it to be a simple program so that your 84-year-old mother won't have any trouble figuring it out, let alone a 64-year-old, or whatever. That's what I am cautioning you against is not to provide lots of help for a very complicated program; let's provide a very simple program as best you can. And I...you know. We didn't do very well in round one.

SENATOR JENSEN: Great. Any other questions? Well, thank you very much. We appreciate all of you who have come up from CMS and we do look at you as partners in this, and so we certainly will be contacting you as we move further along.

FRED SCHUSTER: Thank you. And this is just kind of beginning, even though it's our third official annual trip here. We need to keep the lines of communications open and continue talking and dialoguing before problems become too big, and that's what we hope to do and you take advantage of

it.

SENATOR JENSEN: Great.

SENATOR BYARS: Good.

SENATOR JENSEN: Thank you very much.

SENATOR BYARS: Thank you for being here; appreciate it.

SENATOR JENSEN: We will now begin the hearing of our bills. Senator Thompson is here to introduce the first bill, LB 712. May I see a show of hands of how many wish to testify as proponents on LB 712? One, two, three. Very good. Any opponents of LB 712? One, two. Two, okay. Thank you very much. And we would if you are going to testify, please move to the forward seats so that we can make a very quick transition. We do have a very heavy schedule. I would ask that if you are going to testify, you hold your testimony to a page and a half; that's about three minutes. So, with that, Senator Thompson, good to welcome you again.

LB 712

SENATOR THOMPSON: (Exhibit 1) Thank you. Thank you, Senator Jensen. As all of you know, I am on the Appropriations Committee and we this year again had to look at the cost of prescription drugs and how expensive they are as prices go up in our state budget. And both the Governor and the committee had to approve a 10 percent increase just for this biennium. We have see these costs go up throughout our state programs, but one thing that I learned, big time, on the campaign trail last year was how significant this is to the average person in Nebraska and particularly to the people who have moderate incomes, people who are working who don't have coverage for prescription drugs which is fairly common, particularly for people with average to lower incomes, people who are in the early retiree situation and aren't ready to step into the program that you were just hearing about, and also knowing that there is a doughnut hole in the program that's coming in where people are going to need some help in between when the benefit starts and

stops. And as Senator Johnson mentioned, it is a fairly complicated way that it's set up and there are people who are going to be having significant needs. Nebraska is one of very few states that has ever had a program to subsidize or help with prescription drug costs. At least 39 states...our numbers ranges from 39 to 48, but we took the lower number from the data that we were able to find at NCSL...have some type of pharmaceutical assistance. We're one of the few without. And being passed out to you is a document from the NCSL Web site and I know I have quite a bit of stuff coming around. Oh, there it is. And it shows what is happening in the states starting in 1999 when Maine passed its prescription drug program card. It's been through a couple of court cases. It's operating in Maine. It's now also operating in Michigan and Hawaii. And as you can see from...they have the fully implemented program similar to the one that this bill proposes. And also the other states that have passed it, and you can see South Dakota, Montana, Washington, Oregon, California, Arizona, that are in the process of getting them implemented. We know from at least my service on this committee that there are other groups out there, people with chronic diseases that have tremendous problems paying for their prescription drug costs. And I carried a bill a few years ago to help people who are on immunosuppressive drugs for organ transplants who don't have the ability or their insurance doesn't cover a tremendously expensive, people who are working who are in great financial straits because of that particular cost. I know from being on this committee and subsequently talking with physicians who treat families with children who have mental health disorders who have a tremendous problem paying for their prescription drugs. So those are just a couple examples of who could be served by this particular program. I have an amendment to this bill that after we drafted it and put it out does a little bit in the clean-up category, but also puts more detail to and creates some new sections that describe the process for paying claims to pharmacies that establish a mechanism for collecting rebates from manufacturers and using them to pay claims, and some new language on how the prices are to be determined that I think provide more detail to the bill and were excellent suggestions that were presented to us. There are several people who want to testify and I did work with particularly the AARP in developing this, and they have

quite a bit of information to share with you. Once again, there is a fiscal note that is kind of a surprise and a shock, and we since it has come out we have had opportunity to talk to some of the other states and we'll get that information to you on what it has cost to implement this in other states. They also, we discovered, were presented with these kinds of requirements before they actually got developed and in place, and they are actually fairly, in the scheme of things, appropriately staffed to run, and we could give you those comparisons. It would need some start up money--this is a revolving fund--and would certainly look to a number of possibilities there. I hesitate to mention this because we all like to go there, but a lot of states have used their tobacco settlement funds for these purposes as a public health purpose. One thought would be to start up with some borrowed money that could be paid back because this program is not a subsidy. This is using the negotiating part of the state, which we already use in our Medicaid program; we already use for our prisoners; to be able to negotiate drug pricing just the same as the people who are in prescription drug program through their own health insurance. We would be able to negotiate, be able to use the rebates, and be able to bring those costs down because quite frankly the people that this most impacts, the working middle income and lower income people who don't have a way to pay for prescription drugs. They are the people who are paying retail. The people who are in the immunosuppressive drug category, AIDS, other types of things, and don't have a program, they're paying the sticker price. You'll probably hear that there are cards here and cards there and different things you can maybe sort out and the possibility is out there. We don't have anything for people that is uniform, that creates a system so they can go in for virtually the drugs that they need without having to hope for the charity of a pharmaceutical company or hope for something that might be there and might not be there from month to month or year to year. This is a big need for people in our state. It's a huge problem nationally. We're not seeing a solution to it at the national level. The bill that was passed that you heard about doesn't allow negotiation with the pharmaceutical companies. It's extremely expensive. I think the reason the states are moving on this is because they recognize the problems for people. I hope Nebraska will part of that group that says

we're going to do what we can as a state. Eventually this will be cost neutral because you will be able to just set up a program for those who need it the most and use the rebates and the negotiation to bring the price down for them. So with that I will stop. I know that was a little longer than I usually go but I wanted to give you kind of an outline of how this would work. I am certainly amenable to working with the committee to develop and fashion what would be most appropriate for Nebraska. I think we've got a good starting point. Thank you.

SENATOR JENSEN: Great. Any questions? Yes, Senator Byars.

SENATOR BYARS: Just a question on the preferred drug lists. I think we already have a preferred drug list as far as Medicaid recipients is concerned, do we not?

SENATOR THOMPSON: Yes; yes.

SENATOR BYARS: Okay. Would it be your intention that this preferred drug list would be similar to that?

SENATOR THOMPSON: Yes.

SENATOR BYARS: Okay, thank you.

SENATOR JENSEN: Any other questions? Thank you. Will you be here for close?

SENATOR THOMPSON: Yes. I have a bill up in the other...I'm running a twofer this afternoon and I am planning to stay for this. I'm just going to run across and check. See where I am on the other hearings. Thank you.

SENATOR JENSEN: Thank you. I do have letters of support, one from the National Kidney Foundation of Nebraska (Exhibit 2), and also the Nebraska Association of Public Employees--NAPE (Exhibit 3). They'll be entered into the record.

MARK INTERMILL: (Exhibit 4) Good afternoon, Mr. Chairman. My name is Mark Intermill and I'm the associate state director for advocacy for AARP Nebraska. We have a statement that's circulating, but I do want to say that AARP

strongly supports the establishment of the Health Nebraska Rx Card Program. Nebraskans who don't have insurance pay more for prescription drugs than is paid on behalf of those who do have coverage. As large purchasers are able to negotiate more favorable prices, those costs are shifted to those persons who don't have anyone negotiating on their behalf. LB 712 provides access to negotiated drug prices for those persons who don't have prescription drug coverage. And there are three points that I want to make this afternoon, the first being that many Nebraskans are finding prescription drugs unaffordable. We did a survey in 2002, found that 48 percent of respondents over the age of 50 reported that they experience a problem paying for prescription drugs. The median drug cost was $75 a month, but 23 percent said they were paying in excess of $200 a month. Thirty-eight percent of respondents reported they had no drug coverage and 28 percent said they had taken less medication than required, had cut back on food or utilities, or not filled the prescription. We're in the process of updating that survey. We should have the results within a couple of weeks and we will certainly share the results with the committee. The second thing that I would like to point out is that this process, the Healthy Nebraska Rx Card can be simple. Eligibility would be limited to persons who don't have coverage and who either live in a household with an income below 300 percent of poverty or are eligible for Medicare. Eligibility would be established through a three-question application form as I see it. The department would need to establish guidelines as to what constituted drug coverage and what constitutes income, but once those are done it would be a simple process to determine eligibility. I think there are community organizations that would be willing to help with outreach for this type of program and I can assure you that AARP would be one of those groups that would be willing to disseminate information about the program. Persons who are eligible for the program would receive a card that they could present at participating pharmacies to be able to purchase drugs at the Medicaid price. That price would be average wholesale price minus 11 percent, plus a dispensing fee, minus the value of the rebate that the department can claim from a manufacturer or labeler. The pharmacy would submit a claim to the state for reimbursement of the price reduction attributable to the rebate. We would suggest the establishment of a fund within

the treasury from which claims could be paid and that would receive rebate payments. And then the state would pay that claim to the pharmacy and seek a rebate from the manufacturer or labeler to replenish the fund. The last thing I would like to say is that the cost of the Healthy Nebraska Rx Program doesn't have to be excessive. The Healthy Nebraska discount card program would mirror the payment process used by Medicaid. We don't believe it would be necessary to build a new network or system to manage this program. The prices paid would be to prices paid by the Medicaid program. The pharmacies that participate in the Healthy Nebraska Rx Discount Card Program would be the pharmacies that participate in Medicaid or a subset of that group. The Medicaid program will be handling significantly fewer claims for payment of prescription drugs in 2006 as a result of the implementation of Part D. Claims handling capacity could be shifted to the Healthy Nebraska Rx Discount Card Program. The application process for the Healthy Nebraska Rx Discount Card should not be complicated. There are essentially three questions that will need to be answered. We cannot understand how the determination of eligibility for this program would take more than 15 minutes to complete. A number of states are considering legislation similar to LB 712 this year. A quick check with some of my colleagues has found that estimated costs of the program in Hawaii, which has a population that's about 70 percent of that of Nebraska, is $400,000. The estimated cost in Idaho with a population about three-fourths of Nebraska's is $175,000. We believe there will be start up costs for this program and some ongoing administrative costs, but the ongoing costs beyond the first year of operation can be refunded through the rebates received from the manufacturers and labelers. We estimate the cost of getting this program off to a good start would be a one-time appropriation of $600,000. And then the addition of persons who are able to get discounts through this card will enhance the negotiating position of Health and Human Services System in future negotiation of rebates with manufacturers and labelers. In closing I'd say that we do support establishment of this drug discount card program as described in LB 712. Prescription drugs can and do improve health outcomes but they don't do any good if the people who need them can't afford them. We believe it's in the interest of the state of Nebraska to assist those individuals who are struggling

with affordability of prescription drugs and we urge you to report this bill favorably to General File, and we also pledge...we know this is a new initiative and we pledge our cooperation in discussing further.

SENATOR JENSEN: Thank you, Mark. Any questions? Yes, Senator Byars.

SENATOR BYARS: Mark, you were sitting here while we had the presentation by the representatives from CMS and obviously as we're...as the federal government is gearing up to put into effect Medicare Part D we're looking at starting a new program here. We have the federal government saying they have an interim program, they're starting a new program basically that you've been, AARP has been supportive of. How will the two mix and are we going to be establishing something that just is going to be duplicated in a few months as we get that program started?

MARK INTERMILL: The program in LB 712 wouldn't be available to persons who have prescription drug coverage so if a person purchases coverage through the Part D program, they wouldn't necessarily be eligible for this LB 712 program. Now there are some individuals...I think any individual...any Medicare beneficiary who has out-of-pocket drug costs of about $80 or more absolutely should get the Part D coverage because they will immediately realize a benefit. For those who have lower costs, there is a question. They will have a decision to make. So there may be some Medicare beneficiaries who don't accept the Part D coverage and they don't purchase the Part D coverage. Another issue with Part D has to do with the formulary that's going to be used there. As I understand it and we're still kind of sketchy on the details of the program, there are going to be some drugs that aren't going to be covered through the Part D program. So I think you could say that those drugs...for those drugs, even Medicare beneficiaries who don't have Part D are uninsured for prescription drug costs so there could be a benefit there for Medicare beneficiaries. But the bigger issue is people who are not Medicare beneficiaries who don't have...who won't have the opportunity to purchase Part D coverage. They are the ones who we see as really benefitting from this type of program as envisioned in LB 712.

SENATOR BYARS: Describe that person.

MARK INTERMILL: A 51-year-old individual who has suffered a stroke or who may not be Medicare eligible, who...or any individual who has a chronic disease that requires prescription drug therapy who is under 65 and is not eligible for Medicare disability--those individuals.

SENATOR BYARS: And also not eligible for Medicaid?

MARK INTERMILL: Or Medicaid, correct. Medicaid eligible individuals would not be eligible for the drug discount card. So it's individuals with incomes up to 300 percent of poverty who don't have Medicare/Medicaid coverage and who also don't have insurance coverage.

SENATOR BYARS: Okay. I appreciate it. Thank you, Mark.

SENATOR JENSEN: Any other questions from the committee? Thanks, Mark.

MARK INTERMILL: Thank you.

SENATOR JENSEN: Next person in support, please?

PAT HENRY: (Exhibit 5) I'm not 100 percent sure there are 12 copies there but... Good afternoon, senators, Chairman. I'm Pat Henry of 1460 Buckingham Drive here in Lincoln; it's District 25. And I appear before you today in support of LB 712 for the Healthy Nebraska Prescription Card Program. I may have misunderstood a part of the bill but... Many of us in the state of Nebraska have lost prescription drug coverage because our long time employers have cancelled coverage for retirees shortly before we retired, not giving us adequate time to make other provisions. Others never were employed by a firm which was able or thought it was able to make such promises. The Medicare drug program has not proven to be a solution to all who are on Medicare but it was helped many. My wife and I spend about $750 per month on prescription pharmaceuticals, not including those in the Viagra class. The amount is split about evenly between the two of us. The current Medicare program has proved to be of little use to us but it has helped a number

of persons whom I have had the privilege of helping to enroll in the program. The program will take effect in 2006 may be of some help but it will leave a large doughnut hole which will be burdensome for many. And this is where I misunderstood this program. I thought this program would help the doughnut hole. Last evening I attended a monthly meeting of the stroke survivors and caregivers here in Lincoln at which a new Medicare program was explained to the extent the presenter has been able to gain an understanding of it because a lot is not yet known. There was a great concern about the cost of drug expressed by this group, not all of whom are yet Medicare eligible. Most of this group needs help. I recognize there is an up front cost to this program but the longterm savings to people, whether it is those such as I have just spoken, or the taxpayers of Nebraska through smaller prescription costs to other potential participants such as state employees and their families, Medicaid recipients, institutionalized persons, or others for which the state taxpayer is ultimately responsible should, I think, make a strong longterm cost of the program manageable. I would like to point out here that its efforts to reduce the pharmaceutical costs, General Motors has now announced that it will no longer cover such costs from one national retail drug distributor which refused to negotiate a reasonable price discount. And I think similar approaches could be taken by the state of Nebraska. There may be some alternative funding mechanisms available to support the up front costs of this program as it would apply to those of us for which the state is not currently responsible such as asking us to make a small up front payment, whether it be a premium payment or something that might be refundable over a short period of time for the discounts available. I urge you to pass this bill to help the people of Nebraska to whom it applies. Do you have any questions?

SENATOR BYARS: Thank you for appearing before the committee. Any questions on the part of the committee? Thank you very much for being here.

PAT HENRY: Thank you.

SENATOR BYARS: Next proponent for LB 712. Welcome.

DANIELLE NANTKES: (Exhibit 6) Good afternoon, Vice Chairman Senator Byars, members of the committee. My name is Danielle Nantkes. For the record, it's N-a-n-t-k-e-s. I'm a staff attorney and registered lobbyist on behalf of the Nebraska Appleseed Center for Law in the Public Interest. We are here today to testify in support of LB 712. And since I'm passing around written comments, I'll just keep the oral testimony fairly short and to the point so as to not be redundant. Initially, we believe LB 712 is targeted to the right population. With this handout that's making its way around, I've included some information compiled by the Nebraska HRSA Commission from a December 2004 report that gives you a graphic representation of what population we're talking about of what 300 percent of poverty and below looks like. Additionally, the second point, why we're here to support LB 712 echoes the other proponents. We believe that it's a cost effective remedy. The up front costs targeted to this specific population we believe would provide a critical work support and help low income and moderate income working families continue to work and provide for their health. In conclusion we'd like to thank Senator Thompson for her leadership on this issue and for introducing this bill. Additionally we would ask that this committee advance the bill to the full Legislature. I'd be happy to answer any questions.

SENATOR BYARS: Thank you, Danielle. Any questions of the committee? If not, thank you for being here. Next proponent. Next person in favor of LB 712. No one else being in favor, anyone opposed to LB 712? Please come forward; don't be bashful. Anyone else that is going to testify opposed, please move to the front so you'll be ready to testify upon the conclusion of the next testifier. Welcome to the Health and Human Services Committee.

JACK GEISSER: (Exhibit 7) Mr. Chairman, members of the committee, my name is Jack Geisser. I'm here representing the Pharmaceutical Research and Manufacturers of America. I'm here to testify in opposition to LB 712. This legislation requires the pharmaceutical industry to provide a rebate to the program that is equal to Federal 340B pricing for Medicare eligible residents and for citizens with a net family income up to 300 percent of the federal poverty level. Three-hundred percent is approximately

$28,000 for a single person. We believe based on past experience with other states that this bill would create a new administrative program because there is no PDL in the state of Nebraska. And this essentially would cost the state more money to cover people that are already covered by existing programs. At this point I'd like to start out by discussing the implications of this legislation essentially for the Medicaid Medicare population and also how applying a new PDL with the implementation of the Medicare Part D benefit less than a year away would actually cause difficulties to the state of Nebraska. But I also would like to start out by congratulating the Medicaid department in the state for its preparation for implementation of the Medicaid benefit. The department has been working with others across the nation, with outreach groups and with the federal government, for ensuring a smooth implementation of the benefit for seniors in the state of Nebraska, and I think they really deserve some praise for their efforts and they've done a great job with working with PhRMA and for working with other advocacy groups and with the federal government, as I said, so I think they deserve a lot of credit for that and for their efforts. Now, as I said, the state does not have a preferred drug list, and in creating a new preferred drug list in the state of Nebraska with the implementation of the Medicare drug benefit less than a year away you would actually cause some problems because with Medicare actually assuming with the population of the dual eligibles from Medicaid, you actually cause problems because the preferred drug list in a program focuses on the prescription drugs that are chronically prescribed. Those drugs actually are the ones that would actually would have the most amount of savings in a preferred drug list, so those savings are now assumed by the federal government. And I have actually a handout that I would have...I think you would find useful that would describe some of the problems associated with that because you would actually find that the savings are now assumed...would actually be marginalized. And that handout is an executive summary of a white paper that was done by the National Pharmaceutical Council. And now, with new states, certain states that are looking at implementing a PDL, the savings are now finding that they're being eaten up as high as 60 percent and many states are actually opting not to implement PDLs at this time. And also I think you need to consider that by the

time that this legislation would be implemented, the full benefit would be actually in effect as of January 1, 2006. As of that date at least 77 percent of all Nebraska seniors would be covered into the new lucrative benefit without gaps either through full coverage or with subsidies in the full benefit of Medicare. We have that...that estimate is from the Muse & Associates agencies from Washington, D.C., and I'd be happy to provide more information to you if you would like that at some point later. Now earlier you heard information on the Maine Rx litigation. This bill does closely follow the Maine Rx legislation. It's important to note the Maine Rx program was never implemented in the state of Maine. Yes, PhRMA did sue the state of Maine and I can provide more information on the litigation to you. Maine did not pursue the program because of the scrutiny over the prior authorization procedures in that state, in the court case. And it also did not pursue the program because it knew that it would never seek approval from HHS over the program because they knew that they would have to obtain a state plan amendment from CMS. States that have attempted to do this through a state plan amendment for the amounts discussed in the federal poverty level through the programs have not been approved since. During the litigation the time of the Maine Rx litigation, CMS...or HHS made it clear in a letter to Medicaid directors that when a state plan amendment seeks to leverage the Medicaid population for discounts to other populations, the state must show that the program will further the goals and objectives of the Medicaid program. It is important to recognize that CMS has not approved any requests to serve a population of a 200 percent of the federal poverty level. In fact, the state of Hawaii attempted to get approval of a plan that was exactly 300 percent, the same as this legislation, and they were rejected for a state plan amendment. And in the rejection letter, CMS determined that the 300 percent federal poverty level threshold, and I'm quoting exactly, was not likely to assist in promoting the objectives of the Medicaid program. And I do have another brochure I'd like to pass out, as well; I'm sorry. I do want to point out, we have, as was mentioned earlier, the company patient assistance programs. It was mentioned that we have several programs as far as company assistance programs that match up with 300 percent and 200 percent of the federal poverty level. These programs will be around for many years to

come; they've been around for decades now; they will not go away. But I will say that is you do implement programs like this, many of these programs are programs of last resort so the company...the patients that you are going to be covering here could actually lose these benefits. And I would urge the committee to consider that this bill will attempt to cover a population that is already covered by Together Rx Access, which is a new card that was created specifically for the uninsured upwards to 300 percent. Eleven companies covering over 275 of the most commonly prescribed brand name prescription drugs are already covered upwards to 300 percent of the federal poverty level, and that was a brand new program started for this. And again, just to wrap up, one more point about this. You are hearing that this is a price control on Medicaid prices. This is not specifically Medicaid prices. This is a program that is requiring manufacturers to pay 340B prices for the discount program on a rebate. 340B prices are prices that are much lower than the Medicaid prices. These are price controls that weaken the free market and are anticompetitive. The biopharmaceutical industry, according to the Milken Institute, contributes $584 million to the Nebraska economy each year. And it has been reported by the U.S. General Accounting Office in various reports but specifically in 1997 in a report on this type of program in contributing to state and local programs, the 340B type of pricing, if you try to extend this type of pricing you would specifically have cost shifting to other areas and it would weaken the free market economies again. So by doing that I would just urge the committee to consider these factors and consider the handouts that I also distributed. And I would respectfully urge the committee to oppose this legislation. Thank you very much.

SENATOR BYARS: Questions of the committee. No questions, thank you, Mr. Geisser.

JACK GEISSER: Thank you very much.

SENATOR BYARS: Next opponent.Welcome.

KELLY BORYCA: (Exhibit 8) My name is Kelly Boryca, B-o-r-y-c-a. I'm here representing Pfizer. I wanted to expand a little bit on Jack's comments about the private

sector programs that are available. And I'm having handed out some information on both a Pfizer program and the Together Rx Access program. First of all, I would like to say from Pfizer's perspective, that we get it. We understand that affordability of prescription drugs is an issue. I believe that Pfizer, along with every other major pharmaceutical company, has offered and does offer and will continue to offer patient assistance programs for the low income patient. The second page of you handout talks specifically about Pfizer's indigent programs. Currently we are giving...we gave about 75,000 prescriptions in the state of Nebraska in 2003, representing about $6 million. We have a Sharing the Care program which offers all of our products free to Charles Drew clinic in Omaha, which again targets low income patients. We recognize that low income is not the answer. We've got Medicaid that handles very low income; we have patient assistance programs from all the manufacturers that also addresses patients at 200 percent of poverty or below; and then you have private sector insurance plans. The big hole is the uninsured. And last summer Pfizer started out its first program, called Pfizer Pfriends, P-f-r-i-e-n-d-s, offering major discounts, significant discounts, for any patient who is uninsured. It did not matter what your income level is, you would be offered discounts. If your income level was $30,000 or below for a single person or $45,000 or below for a married family, you were looking at 37 to 50 percent off retail. If you looked at patients who were above that income of $30,000 to $45,000 single/married, you're looking at about 15 to 25 percent discounts. This is for any uninsured patient regardless of income, regardless of age. What Pfizer was hoping is that they would be offering discounts that are comparable to what we offer major employers because, as Senator Thompson pointed out, the uninsured do not have anyone negotiating for them. Since Pfizer introduced that program, the Together Rx Access program was introduced, of which Pfizer is also a member. There are 11 pharmaceutical companies offering, again, significant discounts. Now, here's the deal. The Together Rx Access is 300 percent of poverty or below. But, again, what Senator Thompson pointed out is you've got all these cards and all these programs, and it's very confusing and hard for people to access. And, again, we agree. In Nebraska, you have a clearing house that PhRMA worked closely with the department on. It was

implemented...was implemented...last summer. You have the infrastructure in place and I'm sure that there is someone from the department here that can clarify the specifics of the program. But it would be a one number access. It currently has over 300 pharmaceutical companies, 1,800 drugs offering either free or discounted drugs for probably just about anyone that would call. So PhRMA provided the money for the development of the website, again recognizing that patients need an easy access. If the state is interested in spending money and they want to use private sector solutions, I would strongly advocate that they consider ways to do outreach to let people know how to get into this clearing house and access less expensive drugs. That's it. I think that was under five minutes.

SENATOR BYARS: Thank you very much, Ms. Bori...Bori...

KELLY BORYCA: Boryca.

SENATOR BYARS: Marshall, Marshall. (Laughter) Thank you, Kelly. Just a second.

KELLY BORYCA: Oh.

SENATOR BYARS: Anybody have any questions or comments? Well, I see our Chairman is back. Thank you very much. Appreciate it.

SENATOR JENSEN: Thank you. Next testifier in opposition, please. Anyone else in opposition? Anyone in a neutral testimony? Good afternoon.

GARY CHELOHA: (Exhibit 9) Good afternoon, Senator Jensen, Chairman Jensen and members of the Health and Human Services Committee. I'm Gary Cheloha, C-h-e-l-o-h-a. I'm an administrator with the Health and Human Services System. I'm here to testify in a neutral position relative to LB 712. The purpose of my testimony is to provide information about the activities and programs in the Medicaid pharmacy program and how those might be impacted by this bill, and in turn, how this bill might be impacted by what we have learned and experienced in Medicaid and other programs. I will also provide a little bit of information about other possible approaches to this issue. A little bit of background: From

1997 to 2002, our fiscal years, our pharmacy budget expenditures went up 18.2 percent. In the last couple of years we've done a little bit better--6.6 and 9.7 percent. Rebate collections have gone from $32.8 million in fiscal 2000 to $45.8 million last fiscal year. Between '97 and 2004, the number of prescriptions that we covered went from 2.8 million to nearly 4.5 million. During an average month in 2004, the average number of people receiving a prescription was almost 83,000, and in '97 it was 57,000. We've done some things to expand existing utilization of management of programs and tools and instituted some new programs, as well. The department believes that assuring appropriate drug utilization and maximization of use of equally effective generic drugs are two measures that help assure the availability of quality cost effective medications. The things that we have in place include prior authorization, pricing programs, cost sharing, cost avoidance, and tablet splitting. And some of this will sound like the testimony that you heard in October and some of this is an abbreviated version of that. Prior authorization is one of the main tools that we use to assure that the right medicine gets to the right person and that it's the most cost effective medication. And the approvals that are granted are based on information provided by the prescribing health professional. Prior authorization is intended to balance the interests of recipients in receiving medically necessary medications and the interest of the state in assuring that Medicaid pays for prescribed drugs in an efficient and economical manner. I'll talk a little about the classes of drugs, and there is not a preferred drug list for the state Medicaid program. For the class of drugs called the proton inhibitors, and you've seen the purple pill with the racing stripes advertised, prior authorization has been in effect on this category since December 2002. We save or don't spend about $750,000 a month in total funds, and that was prior to the availability of Prilosec OTC. Prilosec OTC costs about 70 cents a dose. It is now the, what we would term, the preferred drug in that class, although we don't have a legal or a regulatory classification as a preferred drug list. Prilosec OTC is available without prior authorization. We've done the same thing with the class of drugs called the lower sedating antihistamines, which includes Clarinex, Zyrtec, Claritin previously. Claritin or loratadine is now available both

generically and over the counter. It was the first drug in that class, and similar to Prilosec OTC, it is available without prior authorization. Savings from that class, about $200,000 per month. The Cox IIs, such as Celebrex and Vioxx, and everybody knows that Vioxx has been taken off the market. Celebrex is prior-authorized, as is Bextra. By doing that, we save about $250,000 a month over what would otherwise be spent. And the last class I'll talk about before I get into the rest of this is the Cox-I's, which includes some of the older drugs like Naprosyn, and some of those; Mobic is one of the newer ones; and what we have done is place the brand name drugs of those older drugs used for inflammation, arthritis, on prior authorization while allowing the generic versions to be prescribed and dispensed without the need for prior authorization. The savings here are not huge, at $70,000 a month, but there are savings there. Drugs for RSV, for an infant has this indicated, costs about $10,000 per season to treat this child. We have guidelines in place where pediatricians in Nebraska use the American Academy of Pediatrics guidelines to assure that we covered those children that need the drug and do not cover those for whom it's not appropriate. Pricing programs, this Legislature passed statutes and we promulgated regulations to change the reimbursement formula for pharmacy from AWP minus 10 to AWP minus 11 percent in 2002. That saves about $1.4 million a year. We have a very aggressive generic drug program called the state maximum allowable cost, which meshes with the federal upper limit program. The savings from this are, depending on how you calculate it, the difference between the usual and customary are what the pharmacy submits are between 9 and 18 percent of what we would otherwise pay for those same medications--$18 million to $36 million; a very, very significant savings. To further emphasize the importance of generics, in August 2004, an average generic prescription cost Medicaid $16; the brand name cost about $98. Copays went from $1 to $2 in October 2002, so clients that have to pay copy now pay $2; that's a $1.5 million a year difference. Cost avoidance. We require pharmacies to bill other insurers first. By doing that we believe that we are saving about $515,000 per month. Pharmacies are very good at billing the insurance companies and collecting from them. Some of the insurers that have been billed in the past where we paid the claims and chased had restrictions like we didn't bill them

within the 28 days and so we were not able to collect. Table splitting was put in, and Dr. Raymond and I worked on that back in April 2001. We started with Zoloft 100 milligram tablets for 50 milligram doses. We pay the pharmacist a little bit to split those tablets. That product alone saved us $300,000 per year. We have since added other strengths of Zoloft, Paxil, Celexa, and other medications. Savings in six months, about $1.1 million, and we believe that there is no compromise of patient care. So there are some of the programs that we have in place that help control the rate of growth in the pharmacy program. We've not flattened it out but we've slowed it down. Prior approval and preferred drug lists. We believe that the impact of prior authorization as it currently functions in Nebraska Medicaid is superior to the preferred drug list process used by other states in several ways. We believe we save at least as much if not more money, that we, costwise, we do very well. We don't have...the early reports from the states that put in PDLs, the savings were smaller. Michigan made huge headlines with their PDL, saving $3 million a week. That turns out that was about 3 percent of their drug budget. We think we're doing 6 to 10 percent by doing prior authorization on the things that we're doing. The hassle factor for prescribers. Dr. Raymond has worked very hard with the physicians' community to get them to work with us on prescribing and working on the prior authorization prescribing generics. We believe that the program we have, while not a perfect program, is at an acceptable level. We believe that a preferred drug list, we potentially add a number of other medications, classes of drugs that would have to be put on a formulary, practitioners would have to learn those, and that could vary between Medicaid and our health insurance and other insurers, as well. So we've tried to minimize the hassle factor. Some states have contracted with organizations that review classes of drugs to determine which is the most or the best drug in the class and...the Oregon cost effectiveness studies by and large have found that there is no difference within the classes of drugs. We were lobbied to spend state money to join one of those. We can get the results off of the Internet and they by and large have found that there is no difference within the classes of drugs. We believe that that reaffirms our position of prior authorizing all the drugs within a class and then making sure it is therapeutically appropriate for

the client to get that. The requirement within this bill to establish a preferred drug list, and I'm not sure that's exactly what that says, in addition to being a major change in our well established procedures could actually result in increased expenditures by removing products from prior authorization status by simply agreeing to pay a supplemental rebate. We believe that this could lead to excessive growth and utilization and cost, especially for those new, expensive products that are promoted via very highly funded mass media advertising campaigns. What else is there? The Together Rx card program, which you've already heard about, and I'm not paid to say this, but we've been made aware of that program. And my director asked me to find out how many of the products that will be available to the Together Rx Access program, what portion of the Medicaid drug budget would be covered. Ninety-one of the top 100 drugs that Medicaid paid for in January 2005, we paid for either as a generic or with one of the brand names that would be covered under the Together Rx to give you an idea of what that could potentially cover. Merck and Company is expected to announce early next month that they are also coming out with their own discount drug card program. I'm not sure what the income level is but they have told me that their only eligibility criteria would be that the person have no other drug coverage. They have our number 15 drugs in our top 100, and two others in the top 100, as well. Similar brand name drugs that are covered by those card programs include Lipitor, Zoloft, Singulair, and others. I think you were told already by the folks from CMS, I was watching across the street, about the poor enrollment into the Medicare discount card program--14 percent nationally, maybe 13 percent Nebraska. And that's in spite of the fact that there is a $600 credit for last year and this year. I just wonder about...and they spent a lot of money advertising that, promoting that on television and other places, and still only 13 percent of Nebraskans enrolled into that in spite of the fact that there is $600 credit. And Kelly Marshall Boryca talked about the clearing house and the website, and we did, in fact, work with them to establish that website; our Webmaster worked with their person. That website is up and operational. It's Rx4Nebraska.org. It has my office phone number on there. It also has a link to the Creighton University School of Pharmacy for people that have trouble

navigating that website.

SENATOR JENSEN: Gary, do you know how many hits you are getting on that, or do you have any idea?

GARY CHELOHA: I do not. I was asked that earlier. Our Webmaster does not know and I did not get to the person in Washington or Alexandria, Virginia, to find out. I can get that information for you if you would like.

SENATOR JENSEN: Yeah, thank you.

GARY CHELOHA: I've been on there a number of times. I know we've had about 20 because I have gone on there and helped people, so we've had at least 20. The AAA offices also know about that. They were part of, early on in the process they know that that's there. And one other part of that clearinghouse I want to talk about was the concept of a "brown bag" review for patients who will now have...if we can get this clearinghouse more operational. People will have increased access to medications, whether it's through the free programs of the drug companies or the discount cards, or whatever, because it points to all of those programs. I felt that it was important if we increase access to medications that somebody looks at the total profile of some of those clients. Creighton School of Pharmacy, the drug information center, is working with the Eastern Nebraska Office on Aging to review...and with their case managers...to review clients that have certain target drugs or more than a certain number of medications on their profile when they come into the office. And that was a part of the clearinghouse that we felt was important not just to increase access but to try to make sure that the access and then all the drugs the patient was taking were appropriate. That is just more a model or test site; it's not available across the state, and that's one of the issues that we still don't have completely done. Medicaid reform, there is a bill before the Legislature and I think there is a lot of talk at the national level on some of the things that I have seen might allow variation for income levels for different parts of coverage that says maybe you could have higher income levels to get a drug benefit under Medicaid than for other parts of it. And so I believe Medicaid reform is certainly going to be discussed and maybe part of that

discussion could also be increased access to drugs for lower income people. Are there any questions?

SENATOR JENSEN: Thank you, Gary. I really do believe that those "brown bag" reviews, if we can get to that, is very, very important. I have such concern with people who are eight, nine, ten, sometimes even more than that, drugs that they are all using. There has got to be an interreaction between some of those.

GARY CHELOHA: Yes, I believe so too. I have seen some charts that our nurses are reviewing with patients, up to 27 medications.

SENATOR JENSEN: Oh, wow.

GARY CHELOHA: It's just...you have to be right. There has to be interactions. And drugs, treating the side effects of other drugs, and so there are cases like that where a good review and working with the physician and the pharmacists and the patient to reduce that seems as though it would be a step in the right direction.

SENATOR JENSEN: Sure. Thank you. Yes, Senator Byars.

SENATOR BYARS: Thank you, Senator Jensen, and I see Joni Cover from Nebraska Pharmaceutical Association coming after you, so maybe she can answer the question, too. What does this do to my local country pharmacist that's there in the middle of the night when we need him for pharmaceuticals, what does this do from a paperwork standpoint that you say they're good at billing the insurance company, and now here they have Medicaid, they have Medicare Part B, they have all the choice, and then we have another program to fit in between. What does this do to local pharmacists?

GARY CHELOHA: Which...are you talking about, the LB 712, the program created in LB 712, or...?

SENATOR BYARS: Yes.

GARY CHELOHA: I would think it would increase the complexity of their business. I mean, it's another card that they have to bill and we've talked about the cash flow

issues and the fund that was talked about earlier, maybe Mark or somebody else talked about creating a fund to pay the pharmacists so that the discount could be given to the patient. It's another kind of insurance; it's another card. The computers do a very good job of tracking that, but it does increase the complexity of the book of business that they do.

SENATOR BYARS: Okay, thank you very much. Appreciate it.

SENATOR JENSEN: Any other questions? Thank you for coming forward. Next testifier in a neutral position?

JONI COVER: Hi.

SENATOR JENSEN: Hi.

JONI COVER: Senator Jensen, members of the committee, my name is Joni Cover; it's C-o-v-e-r. And I"m the executive vice president...

SENATOR JENSEN: Please spell you first name.

JONI COVER: What?

SENATOR JENSEN: How do you spell your first name?

JONI COVER: J-o-n-i.

SENATOR JENSEN: Thank you.

JONI COVER: And it's Cover, not Cuver (phonetic). (Laugh) I was not really going to testify today, but after listening to all of the testimony before me I just felt like I needed to put in a few remarks. I appreciate a lot of the things that Gary said. I think that the Medicaid program that we have in place, the prior auth program, has done a very good job in reining in the costs for the state. I would like to know, and I should have asked Senator Thompson this, how many people in Nebraska don't qualify for Medicare, Medicaid, or any of the other programs that are already out there. I don't know that. There could be a lot of people that this impacts, and I honestly don't know. So that's one question. There was one thing in the bill that popped out

that pharmacists may have to keep the medication inventory separate than their other inventory. And just from a size of a pharmacy, that could be a logistical nightmare. I understand maybe why that would occur, but I can't imagine too many pharmacists are going to say, well, okay, here's this stock and here's this stock and here's this stock. So I think that might be an issue. Senator Byars, you asked about what the pharmacists think about this. When we read the legislation this year and sent the information out to the members, they said, oh, good, another card. We have not had the best luck with the Part D card. I guess it's not really a Part D card because Part D doesn't start until 2006--the pre-Part D card. We have what typically happens is people come into the pharmacy to pick up their prescription and they take out of their wallets several cards, and they say, here, put whatever medications I have on whatever card will work. And it takes a lot of time. And it can be quite a hassle. We had suggested to Medicare that they pay the pharmacists instead of hiring people to answer the phone at CMS, to answer the questions of the folks that are coming into the pharmacy saying, which card should I get? And that did not occur. And so I can just tell you from a logistical business standpoint, the cards take a lot of time. I do believe that there are some very beneficial cards out there. I do think that prescription drugs are expensive. But there are a lot that goes into the cost of those drugs. And so I would just like to offer our assistance with this program if it does advance, and to let you know that we were involved in the clearinghouse program, as well, and helped...I guess really didn't help, but promoted the "brown bag" review program, as well. So there's my two cents, and if you have any questions.

SENATOR BYARS: Thanks, Joni.

SENATOR JENSEN: Yes. Any questions? Thanks for coming forward.

JONI COVER: You're welcome.

SENATOR JENSEN: Anyone else testify in a neutral position? Senator Thompson, do you wish to close?

SENATOR THOMPSON: (Exhibit 10) I remember a citizen coming

from Sarpy County and passing out all my testimony and realizing it after I sat down and it was very embarrassing for me, and I almost did that again. What is being...just a few things. Let me put this in context. No one denies that we have a huge problem out there. One of the reasons we have a huge problem, quite frankly, is because pharmaceutical companies are one of the highest industry...the industry in this country where you can make a lot of profit. They make a lot of profit. Now I think you're seeing some reaction to the information that the public knows about the fact that this costs a lot of money to get these drugs and they are very profitable. I think also we also know from our legislative work that there are people who are not covered by any pharmaceutical coverage. And the fiscal note says that maybe 25,000 people. When Maine started their program it was about 275,000 people. They have the same population that we do. I know from attending conferences that we do get a lot of enthusiastic support in our work from people that are touched by this problem. And the fundamental question comes down to the same thing you asked every lobbyist who came up at the last hearing: What is the role of government? I think the role of government is to give a comprehensive solution to a problem, one where people don't have to have 50 cards, one that they have confidence in, one that isn't subject to the whim of an industry deciding one day to have it and one day not, something that people can count on, something that people in the industry can count on, and something that we as state senators looking at a huge problem for the public. Some of us are lucky enough to have had prescription drug cards. I can tell you ten years ago my copay was five bucks. Today, it's $45. And if you want to look at our state budget, the costs have gone up tremendously. So where do you want to give the public some solution to the problem? Does it come in a patchwork sort of way that may be here today and gone tomorrow, or is it something that we can deal with and make sure that the people who are the working poor and moderate income people have a way to count on how they're going to be able to get their prescription drugs. Probably a big section of this is those early retirees or people who have already retired who aren't able to get to the Medicare program yet, and when they get to the Medicare program you heard about the doughnut hole, and I wasn't here because I was in another hearing so I don't know how much

information you've had presented about that, but that drug program covers it, doesn't cover it, comes back in, and that was all put together so that you could hit a target number in the federal budget, which by the way is now almost double that original estimate of what this program is going to cost. My intention with this bill is to cover the doughnut hole; anyone who doesn't have the ability to get prescription drug coverage is covered. I want to go over a few of the criticisms that were here. First of all, this is an article, a recent article a couple of people gave this to me, and also information on the Maine Rx-Plus card which is in place, and that's information about how that particular program is operating. I want to make it clear that this is not just a senior citizen program, which some of the testimony kind of was indicating. This is a program for anyone, any family, any individual who is not covered. The issue of prior authorization was mentioned. That is mentioned in this bill and has worked successfully. If you want to eliminate the preferred drug list, you know I'm willing to talk to you about that. I think that's the way it's worked effectively in other states and we are one of the few places that hasn't gotten to that. The reason the federal drug cards were mentioned before, the reason they didn't work is because quite frankly they stink. And what we need to do is have good public policy; I think that's coming from the states; I think that's coming from the states. The federal government seems paralyzed on this issue other than for the senior citizen issue, and even that is not a very...is not a comprehensive program. But if we're going to be good policy makers, we should be looking at not something that's temporary; not something that's maybe going to be there today, not going to be there tomorrow. We need to help people have long range ways to solve their problems, and this is a problem that we have a duty to help with. So I'm willing to work with the committee in any way that you so desire. It is not intended in any way to hurt the pharmacists. We've made sure and with the amendments, I want to make sure that's in place. I can tell you that small pharmacy owners and pharmacists were the first to come to me when I was discussing this issue a lot on a daily basis and say it breaks my heart when I can't help someone when they come in, find any way to help them pay for those prescription drugs. It's not comprehensive. Said it is heartbreaking, and the amount it's costing them

is heartbreaking. If the pharmaceutical companies want to run their own cards and they say they're saving people 15 to 20 percent, what difference should it make to them whether we have a comprehensive card as a state? It's the same deal either way. I think we need to look to solving the problem for people. There are people suffering out there because of this and I think we should look at it in a comprehensive manner. Thank you.

SENATOR JENSEN: Great. Thank you, Senator Thompson. Any questions? Thank you.

SENATOR THOMPSON: Thank you.

SENATOR JENSEN: That will close the hearing on LB 712. Senator Stuthman is here to open LB 725. Okay, thank you, Senator; I think we're ready to begin.

LB 725

SENATOR STUTHMAN: Okay. Good afternoon, Senator Jensen and members of the Health and Human Services Committee. My name is Arnie Stuthman, S-t-u-t-h-m-a-n, and I represent the 22nd Legislative District. I am here before you today for the hearing on LB 725. Everyday in the Health and Human Services Committee we have hearings on important bills. Many of these bills could help people who need better healthcare. As committee members, we are forced to make very tough decisions, decision that killed good bills because our budget cannot support the programs being proposed. Today I'm asking you to consider a bill that will save thousands of dollars each year. I'm asking you to use the common sense approach. Everyday the community health centers described in LB 725 are forced to throw away medications that could be used to help someone in need. When an indigent patient comes to the community health center, needs medication, and cannot afford to buy it on their own, they can apply for patient assistance medication through pharmaceutical companies. If the patient meets the income requirements and has a prescription, they can receive certain medications free of charge or at a dramatically reduced rate. Pharmaceutical companies issue these meds oftentimes in 90-day supplies. These meds are labeled for a

specific patient and dispensed directly to the health center. From there, the meds are kept under lock and key until the patient arrives to pick up these prescriptions. The problem is that many times these drugs are not picked up. A patient may have moved away, the prescriptions may have changed, or they may have become allergic to the drug. So the meds will not have been picked up. They sit unopened, unexpired, untampered with, and undistributed. The pharmaceutical company will not take back the drugs by the law or the health center, cannot give these drugs to other patients in need--they cannot do this. Meanwhile, there are other patients dying for medications but the law says the health center must throw these meds away. This bill will allow the health center to have a licensed pharmacist come to the health center and relabel the meds for another patient who has a prescription. Realistically, I don't see any good reason why we should not support this bill. Opponents of LB 725 will worry about that these meds might be tampered with or that they will be given to wrong people. In my opinion, there is no greater danger of these meds being contaminated or tampered with if they are relabeled than if they were distributed to the person on the original label. As you consider this testimony today, please keep in mind that these meds have been under the constant protection of the staff at the community health centers and have never left the locked room. In other words, these drugs have never been in the consumers hands and will never be used by anyone else unless we pass LB 725. Every day we deal with skyrocketing healthcare costs and dramatic budget shortfalls. LB 725 is a great opportunity to save money and help someone in need. I urge you to consider this legislation.

SENATOR JENSEN: Thank you, Senator Stuthman. Any questions from the committee? Thank you. Becky Rayman, is that the name?

REBECCA RAYMAN: (Exhibit 2) I have a handout and visuals.

SENATOR JENSEN: Great.

REBECCA RAYMAN: First of all I would like to thank Senator Stuthman...oh, my name is Rebecca Rayman, R-a-y-m-a-n, unlike Dr. Raymond. And I am testifying today on behalf of

the five community health centers in Nebraska. I would like to thank Senator Stuthman for introducing this bill. It is a marvelous piece of legislation that will help a lot of vulnerable people. I would like to tell you how you can put into our own health center, just one of five health centers, and every six months we're throwing out over $40,000 worth of medications that are not expired, not opened, and untouched by any patients. These are the patient assistance medications. I actually took these out of our locked drug room this morning. This is a bottle of Lipitor. It's 90 tablets. And the retail on this is $305.79. This is a bottle of Abilify. This is a 30-day supply of Abilify, which is psychotropic drug for mental health patients. The retail value on this is $314.79. And there are many more drugs and types of drugs in our drug closet. There has been so much testimony this afternoon on the pharmaceutical crisis, and I'm not going to go over that. You've already heard testimony on that. But I would like to tell you a little bit about our health center. Earlier in the year we started a 340B drug program and we were so excited and we contracted with a local pharmacy. And it's a wonderful program; it allows us to buy drugs at a reduced cost to offer to our patients. And our health center patients that come to our health center, 95 percent of them are 200 percent of the poverty level or below. And so they're a very vulnerable population. So we were really excited and we contracted with a local pharmacy. And about two months into the program I got a call from the pharmacy, and they said we're not going to fill your patients' prescriptions ahead of time anymore. And I was like, you know, well, why would that be? And he said they're not picking them up. Four out of five of our patients were not picking up their medications; that's 80 percent of the people. And the reason that 80 percent of the people couldn't pick up their medications is because they couldn't afford the drugs, even at a discount. And that just kind of shows the problem. If you are living on $551 a month disability and your drug bill is $400, even if you discount that to $200 that doesn't leave enough for that individual to live on, and so they were sacrificing the drugs. We've all heard testimony that individuals sacrifice food, that they sacrifice their medications when they're in that position. And that's what was happening with our patients. We work very hard to get all of the patients that we're able to on the patient

assistance programs from the pharmaceutical companies, and these are wonderful programs. They offer the drugs at free or reduced price. They're available to patients who have a chronic condition. They have to be uninsured. Generally, they have to be 100 percent below the poverty level. There are programs that extend it to 100 percent but many of them are limited to 100 percent of the poverty level. And you have to have a Social Security card. Now, our particular health center serves 63 percent Hispanic/Latino individuals, and not all of those individuals have a Social Security card; not all of those individuals are able to fill out the patient assistance forms and receive the medication. At our center last year we did over 1,000 applications for patient assistance for 343 patients who did meet the qualifications. In a nine-month period, as I said, over $40,000 worth of very expensive medications had to be destroyed because either those patients moved--we serve a migrant population at community health centers. A lot of times individuals will move from the Columbus area to another area and they won't be there anymore for their medications or the patients' medications change. And this is a especially true for mental health. Our community health center has a very active mental health program. Last year we did about 1,200 mental health encounters. We have a psychiatrist, and psychiatrists are always needing to adjust the patient's medications or to change the medications. And we literally are, at one counter telling a patient I'm so sorry we're able to help you receive your medication, while we may have nurses in the back flushing the same medication that that patient asked for, down the drain. And so it's very painful to do that, to know that you have something that you could give someone but you're unable to do it. Our drugs, when they come into the center, are very highly regulated. They come in, we actually have a locked room. It has a keypad on it so you have to punch in a code. We have a refrigerator for our medications. So the medications are always under our control. These medications never go to a patient's home. Once they are picked up by a patient who needs them, we would never take them back. So these are our medications. They have the foil on them and they are untampered with. I would like to thank you for allowing me to testify today and I hope that you will consider this bill. It is kind of a win-win situation. It doesn't cost anything for the Legislature to provide this service and you

will literally benefit a lot of patients who would have no other access to medication.

SENATOR JENSEN: Thank you, Ms. Rayman. Senator Byars.

SENATOR BYARS: Thank you, Senator Jensen. And I'm presuming that $40,000 worth of drugs that I suppose the pharmacist was the person who ate the whole cost of that?

REBECCA RAYMAN: These drugs come from the pharmaceutical companies...

SENATOR BYARS: Okay.

REBECCA RAYMAN: ...and so the patient fills out an application form. They need to provide proof of income, maybe a tax return. Sometimes we have to copy cards.

SENATOR BYARS: Okay, but I mean the $40,000 worth of drugs that weren't picked up at the pharmacy, the pharmacy said they were no longer...

REBECCA RAYMAN: No, these are drugs that are shipped directly into the health center so they come directly to a provider at the health center and they never...they come into the health center and they're stored at the health center.

SENATOR BYARS: Okay. So this doesn't even include how much money the pharmacists who called you and said they were no longer going to fill those. This doesn't include...

REBECCA RAYMAN: Right.

SENATOR BYARS: ...how much money they lost with prescriptions sitting there.

REBECCA RAYMAN: Those prescriptions were actually prescriptions that we were sending over on a prescription pad. We fax our prescriptions into the pharmacy. And originally they were just filling them, you know, and setting them aside so that when our patients came...

SENATOR BYARS: Sure.

REBECCA RAYMAN: ...but now when our patients go to the pharmacy they have to wait and then the pharmacists will fill their prescription at the time they come into the pharmacy.

SENATOR BYARS: Okay.

REBECCA RAYMAN: So it's just kind of a separate issue but that just goes to show you that even when you have a good discount, health centers serve the most vulnerable population so even when there is a good discount we serve a lot of people who are at a very low income level and who are uninsured. Health centers in Nebraska serve, on average, 72 percent of the population that they see are 100 percent below the poverty level.

SENATOR BYARS: I appreciate it very much. Thank you.

REBECCA RAYMAN: You're welcome.

SENATOR JENSEN: Yes, Senator Johnson.

SENATOR JOHNSON: A question along the same line. So those two boxes in front of you there are roughly $300 apiece.

REBECCA RAYMAN: Right.

SENATOR JOHNSON: So the patient had...paid nothing for those.

REBECCA RAYMAN: Those were dispensed to them from the pharmaceutical company.

SENATOR JOHNSON: But the patient paid nothing.

REBECCA RAYMAN: The patient paid nothing.

SENATOR JOHNSON: Well, see, what I'm getting at is I find it very interesting that here someone walks away from someone handing them $350.

REBECCA RAYMAN: They probably didn't walk away, Senator. Their medication might have been changed. So it might have

been found. They come in three-month's supplies so we might receive three bottles.

SENATOR JOHNSON: But my point is that if there is no value to the patient then he doesn't care, so, you know, I can see a lot of benefit in the program that you are providing. But at the same time I think we have to admit that when the patient has no investment, that $350 box of pills you have there has no value to the person if he has no investment in it.

REBECCA RAYMAN: Yeah, I think that the patients, by far the majority that we have of these drugs that are left on our shelves are because the physician changed the prescription. So it might be, for example it might be a diabetic patient who is on insulin, Senator, and then at their next visit with the provider their blood sugar was in better control, maybe they needed to step down to an oral hypoglycemic, and so then...

SENATOR JOHNSON: But inefficiency in the program would be part of the problem then.

REBECCA RAYMAN: I'm not sure I understand.

SENATOR JOHNSON: Well, you have two (laugh) examples in front of you of medications that were provided to the patient and then weren't used.

REBECCA RAYMAN: Right.

SENATOR JOHNSON: So, you know, and you may be well be right in the reasons and so on, but the pills are still there.

REBECCA RAYMAN: Right. And that's exactly the point. The pills are still here sitting on our shelf and I have another patient I can't give them to.

SENATOR JOHNSON: My point is, as I get back to again, is the prevention angle.

REBECCA RAYMAN: Um-hum.

SENATOR JOHNSON: We made a mistake by providing those pills

to that patient.

REBECCA RAYMAN: I think there is an individual who is going to follow my testimony who is a patient of our who receives patient assistance. And for that individual and for the other individuals who receive those drugs from us sometimes that means life or death to them, so.

SENATOR JOHNSON: But you're not...you're avoiding my question.

REBECCA RAYMAN: I'm not understanding, I guess.

SENATOR JOHNSON: And I believe in what you're saying; I don't mean to say that.

REBECCA RAYMAN: Um-hum.

SENATOR JOHNSON: But, you know, when you show up with $700 of pills in front of you...

REBECCA RAYMAN: Right.

SENATOR JOHNSON: ...that are going to waste, a mistake has been made.

REBECCA RAYMAN: Not especially. It's hard to explain, but it's like if I...if we have a patient who comes in and that patient has never had...let's say the patient has never seen a physician. We have a lot of patients who come to our health center that have never seen a physician. And they are examined by the physician and they are found to have a condition and they prescribe them some medication. And maybe it's for high blood pressure. And so for that particular patient the response to that high blood pressure medication is that their blood pressure goes too low. And we have given one of them three bottles that came in because they would receive a 90-day supply so they might receive three 30-day supply bottles. And if we've given them one month's supply and then the physician finds that that particular medication is not working well for that patient, those other two months would go to waste. The patient may come back but the medication goes to waste.

SENATOR JOHNSON: I won't pursue that anymore, but...

REBECCA RAYMAN: Oh, okay. And I'm sorry, Senator, if I'm not understanding you.

SENATOR JOHNSON: Well, let's just go on.

REBECCA RAYMAN: Oh, okay. Thank you.

SENATOR JENSEN: Okay. Senator Cunningham.

SENATOR CUNNINGHAM: Just a little bit, to follow through, maybe, Senator Johnson, are you saying that maybe we shouldn't have had a 90-day prescription if we didn't know the medication would work? Could that be...?

SENATOR JOHNSON: That sort of thing.

REBECCA RAYMAN: Yeah.

SENATOR JOHNSON: I'm looking for prevention...

REBECCA RAYMAN: Sure.

SENATOR JOHNSON: ...rather than trying to cure the problem, and you may have a good cure.

REBECCA RAYMAN: And I can understand that the drugs do come from the pharmaceutical companies in 90-day supplies, so.

SENATOR CUNNINGHAM: Do both of those have tamper proof seals on them, or...?

REBECCA RAYMAN: These have never been opened, so.

SENATOR CUNNINGHAM: But I mean, they just...

REBECCA RAYMAN: There should be foil in a...

SENATOR CUNNINGHAM: Does everything come with foil?

REBECCA RAYMAN: Yeah.

SENATOR CUNNINGHAM: Okay, okay.

REBECCA RAYMAN: It's like, you know...it's just never been opened, so.

SENATOR CUNNINGHAM: I've got a lot of trash cans in my office if you want me to throw that Lipitor away. (Laughter)

REBECCA RAYMAN: Actually, I am going to take these back to the health center because I have so much faith in the senators on this committee. (Laugh)

SENATOR JENSEN: Any other questions? I will say I've been up to their facility in Columbus, and it was such a joy to do that and to see the work that they're doing and the number of patients that they're serving, really many times without question as to if they can pay, if they are actual citizens. And so the services that are being rendered up there are outstanding and I really applaud you in your effort, as I do all the FQHCs. So if you ever get the opportunity to go there, do that. I think you'll be well rewarded. Yes, Senator Byars.

SENATOR BYARS: Senator Jensen, and I would suggest that. I would hope the committee next summer, but that maybe in our interim or next fall, we would have an opportunity to take the new members of the committee to visit some of the federally qualified health centers...

SENATOR JENSEN: Great.

SENATOR BYARS: ...community centers around the state and some of our public health offices. I think it would be very... (inaudible).

SENATOR JENSEN: And Senator Stuthman said that he would take us to a very nice restaurant up there. (Laughter)

SENATOR BYARS: That's what I understood also. I can tell you which one it would be, I'm sure.

SENATOR JENSEN: Okay.

REBECCA RAYMAN: Thank you so much, senators, and I'll pass

on those compliments to our staff. They work very hard. Thank you.

SENATOR JENSEN: Thank you. Next testifier in support, please.

MERLANN GUSMAN: Good afternoon, members of the Legislature. My name is Merlann Gusman, M-e-r-l-a-n-n G-u-s-m-a-n. And I'm the recipient of this program that they have there are their community health center there in Columbus. Last year I was able...I had become ill, lost my job, unable to work. In the year 2003, I was a $40,000 income family. In 2004, I only had $10,000. Okay, when I lost my job, I lost my insurance, of course. They want this huge amount of money, you know, to carry on your insurance, but you lose your company benefits, you know, of group insurance, everything. And so I had a slight stroke; I'm a retired RN now. I had pneumonia and I had kidney problems. So my whole year was just...I got medical bills that just stagger. Well, my first concern was the medication. Okay, I couldn't buy any medication. You know, where was I going to get help for this medication? I needed $500 a month with all the medication they stuck me on all of a sudden. You know, I'm a diabetes also on top of that and I've got depression and I've got hypertension. Okay, when I came out of the hospital my sister took me in because I lost my house, lost my car, lost everything because I couldn't all of these things, so anyway. And she couldn't afford my medical...proper medication. I either had to do without...well, in my condition you can't do without...being a diabetic you can't do without insulin very long; you can't do without high blood pressure medication. There I was stuck in this thing...and very, very frightening. I was scared to death. So we started asking around. We went to the computer. We looked up things about places where we could find some help. But in the meantime, who was going to help me with these bills? We have the...I am now on the prescription plan so I'm between pharmacies. This one is GlaxoSmith, this is from the Hy-Vee, and then this is from the clinic out there, the Lipitor is from the clinic at the community. But in order to get on these programs you have to wait awhile. Okay, I didn't have the medication to wait. Where was I going to get help? Who was going to help me? You know, I (inaudible) help, I had no way of paying for

these drugs. I was very scared. I walked into this clinic out there at Columbus. A friend, social service, Health and Human Service recommended me to go out there. So I went to them first, I says I need help; I don't qualify to Medicaid; I'm not disabled; I'm not...I don't have any children anymore that are home. And so they sent me out there and I walked in there in tears, you know. (Crying) And they worked with me...excuse me...very much, and they had...they started changing medications that they had there to substitute for what I was taking because they didn't have some of these. So, Dr. Joe, he says, well, let's work with this. He says we've got medication here, let's see what we have got that could replace some of these that you have that we don't have. And so they gave me enough medication to get me through because it takes time for this to all go through the pharmacy that sell medication. I get help from the Lilly company, I get help by GlaxoSmith, I get help from Pfizer--three different things. And then I get help from the Hy-Vee now that have a discount here for my certain medications, and I get...you know, I got help but it took time to get this help. (Crying)

SENATOR JENSEN: I understand.

MERLANN GUSMAN: So if it wasn't for this community health center and their drug program there that they had available to me. My medicines come out, they were sealed. The ones that were on cards were counted, dated. They all had expiration dates on them. And they had no names, just me. They put a little sticker on it that said this is for Merlann Gusman now. These are the ones that got out there, they're sent from the pharmaceutical company send mine directly to them. As I said, they put my three-months' supply in a bottle--one bottle. If they can, they do that. And they bottle and label them. These...of course, these here, come directly to me and they were put in these bottles by the companies sent out. They weren't sealed but they come straight to me from the pharmaceutical company and there is three months' supply in one bottle. So I don't have extra bottles siting around out there. But before the three months is up I have to make sure I get, when they're half done, reorder because it takes that long a time. But if these people hadn't given me this medication to tide me over, I might now be alive today. So I was very thankful

that they did help me. And, yes, I cry easily, but that's okay too because it was a hard time. (Crying) And I'll be back to work someday and maybe not for awhile yet, but not in my RN career because it is impossible there. I've been a nurse since 1962 and I worked at a good career; I loved it. So thank you for letting me tell you my story.

SENATOR JENSEN: Thank you. I sure 2005 is better than 2004 for you.

MERLANN GUSMAN: I hope some of this helps out with this bill going through because it's very important to some people because my daughter, I took her there, she got...she had just come of Medicaid. She didn't have...she ended up with an ulcer all of sudden. She started a new job, but it takes three months there, of course, for her to get help, you know, to sign up for your insurance, and she was in the hospital. They ordered Protonix which is $250. They ordered antibiotics which was $160. There is no way she had money like that to pay for it. We went out to the clinic out there. They revamped it. Now we may have got a second...we couldn't afford the 100 percent guarantee of cure. We was dropped to an 80 percent by changing the drugs to something we could afford. We ended up paying $60 just for these drugs that we could afford. But it was 80 percent curability but it was better than none at all or the 100 percent. But these here along with diet and and stuff, if would help. But if it wasn't for that place out there, I don't think we would have made it. Now, we're not going to be this way. It's just a temporary thing, you know, but it's there and it's for people who can't get there. I'm 61 years old now starting all over again with a new career. Hopefully I can probably help somebody else with their things, so I appreciate the time that you guys gave me and...

SENATOR JENSEN: Thank you. Any other questions? You are fortunate you are in a caring community.

MERLANN GUSMAN: Yes, it is. I worked many years in Nebraska as an RN. Traveled across Nebraska and now I'm retiring because I can't quite handle the job that I was meant to do.

SENATOR JENSEN: Well, thank you for coming forward. Anyone else wish to testify in support? Anyone in opposition? Anyone in a neutral testimony?

JONI COVER: (Exhibit 3) Good afternoon, again. My name is Joni Cover, it's J-o-n-i C-o-v-e-r, and I'm the executive vice president of the Nebraska Pharmacists Association and I just have a few technical comments about this legislation. And I would like to thank Senator Stuthman for visiting with us. He and Lori have done a great job in answering a lot of our questions and we discussed me bringing these issues to your attention and he is well aware of that, so. I won't read you what I wrote. I'll just go over quickly the issues that we have. We are suggesting because of the potential liability, and this was something that was also brought forward by our pharmacists mutual liability insurance carrier, that we include some sort of immunity language that's included in the cancer drug bill and the nursing home returns bill. And I've attached the cancer drug immunity language in there. The second thing, of course, is we're always concerned about controlled substances. And so attached to the document that I handed you is the federal law that talks about the labeling requirements of controls, or Schedules II, III, and IV, and so I want to make sure that the provision gets added to the bill. And then finally, and Senator Stuthman and I had discussed this, we were not real crazy about the mandatory language that pharmacists must participate in the program. And so I have added language in here that we proposed to make it a voluntary program. And then I also tried to correct a technical wording change. In the bill it talks about paying pharmacists fees, and what we would like to do is clarify that that's dispensing fees. I don't know exactly how this program is going to work and I'm not sure because of...we've dealt with returns before but we're never dealt with relabeling. So we may need to have some more conversations about this. One of the concerns we had one of the pharmacists brought up was, will it look like that pharmacists are trying to sell samples; are we getting paid to dispense samples? And the question is, I don't know. So that's why we clarified the dispensing fee portion in there. And with that, I look forward to working with the committee on this issue. And I would just recommend that I hope you have a really good pharmacist who is doing drug review for

you because you're going to lots of pharmacies and getting lots of different medicines, and so I hope your healthcare practitioners and pharmacists are working together. So anyway, that's my two cents. Does anybody have any questions?

SENATOR JENSEN: Thank you, Joni. Any questions? I don't see any.

JONI COVER: Okay, thank you.

SENATOR JENSEN: Anyone else wish to testify in a neutral position? Senator Stuthman, do you wish to close?

SENATOR STUTHMAN: Thank you, Senator Jensen. First of all, you know, I've been in conversation with Joni Cover, and I think we're going to be able to work this out. Another thing that I do want to mention and I think I want to clarify some of the discussion that we had with Senator Johnson there. On these medications, these examples of the medications and the second testifier, the amount of time that it took before she would have received the medications and not being on the medications. These medications, the way I understand it, have been applied for by an individual. That individual's name is on there. It may have taken 60 days to receive those medications. In that time period that individual has either left the community or only used one bottle and then the medication was changed by the attending physician there. These medications realistically come free from the pharmaceutical company. They're not costing us anything, but like Senator Johnson was saying that someone has made a mistake. No, someone has not made a mistake. The realistic thing about this is that we are trying to utilize those $300 for someone like the second testifier if that drug was the one that was prescribed, had a prescription for it, because the other individual was not utilizing it anymore or never did come back to receive that free medication. Yes, it's not costing anybody but it's costing the pharmaceutical something to provide that drug, and we are in turn just flushing it away. And that's the common sense thing that I'm trying to avoid and that's what Rebecca Rayman is trying to do also. It's just that the second testifier comes there, needs some, has no money, but we can't provide any, but tomorrow we have to flush that

same thing down the drain. And that's the issue that we're dealing with. So with that, I'm willing to work with the committee but I hope that we could do something. So I'll try to answer any questions.

SENATOR JENSEN: Thank you. And you're also willing to have the committee come up again?

SENATOR STUTHMAN: Yes, I will invite you up there and I'll take you out to Duster's.

SENATOR JENSEN: It doesn't get any better than that. Any other questions of Senator Stuthman? Thank you very much. That will close the hearing on LB 725. Senator Johnson is here to introduce LB 318. (Also Exhibit 1)

LB 318

SENATOR JOHNSON: Senator Jensen, members of the Health and Human Services Committee, for the record I'm Senator Joel Johnson, J-o-h-n-s-o-n, representing District 37. A few weeks back I was approached by members of the pharmaceutical industry, not for a problem regarding retail, but a wholesale problem. What they were talking about is the potential need for Nebraska to implement a program where we prevent introduction of counterfeit drugs in our drug distribution system. The materials that they supplied me, one of these materials caught my eye. And what is was is a article in the New England Journal of Medicine of April of last year. And for those of you that aren't aware of it, the New England Journal of Medicine is one of the world's top medical journals. So when they have an article like this, it catches your attention. I might read a paragraph and only a paragraph of what they said. "Counterfeit drugs can be introduced successfully into the legitimate drug supply if the seller conceals the drug's origin and the purchaser accepts without question the seller's representation of the product. Typically counterfeiters commingle counterfeit product with authentic product and either fail to give the purchaser a pedigree," that is a statement of origin, "or give them a fake pedigree. Commingling makes it easier to pass off counterfeit drugs as authentic and it increases the profits for the

counterfeiter." In 1903 (sic), there were 18 million Lipitor capsules and this affected 600,000 patients. The repackaging that permitted the counterfeiting was done in Lexington, Nebraska. Nebraska is one of seven states where there is no licensing of the wholesalers located outside of the state of Nebraska. The key points of this legislation are, one, regarding licensing requirements for the in-state and out-of-state wholesalers. They would have not only business checks but criminal background checks, as well. As we did with a bill awhile back, a named facility rep would be required and a surety bond would also be required. The other part of this is the pedigree. And drug pedigrees help prevent the high risk counterfeiting meds for, as we just got done talking about, the ones that have some medications that are going to be counterfeited are the ones that cost a lot of money. A pedigree is kind of just like what we get when we buy a high quality dog. It's a historical marker at each stop along the way from the manufacturer to the retailer. At the present time, this is a paper trail. One of the neat things that I found out in looking into this however, is that there will soon be an electronic trail. In about two to three years it will be possible, like we have at the grocery store now where we have the bar graph, it will possible in two to three years to implant a bar graph the size of less than a grain of salt on the package so that you will be able to follow these medications electronically. One of the things is it's easier...and this sounds crazy...but it's now easier with less penalties to counterfeit drugs, medications, than it is dealing with illegal drugs. Now, here's where we're at today. Ninety percent of the medications are distributed by just three wholesalers. However, to do the other 10 percent, there are 6,000 wholesalers. Of these 6,000, less than 100 of them belong to their national trade group. So what we're going to ask you to listen to today is how can we implement these problems in preventing what has happened and certainly will become more prevalent if we don't do something. The only real objection that I could foresee is from the we are going to eliminate some of the 6,000 wholesalers. But they're doing only a very small amount of business and if they play by the rules they can continue their business. Any questions?

SENATOR JENSEN: Thank you, Senator. Any questions? Is the

operation in Lexington still...?

SENATOR JOHNSON: No. I think it was shut down.

SENATOR JENSEN: Okay, good. Senator Cunningham.

SENATOR CUNNINGHAM: Yes, Senator Johnson, just a quick question. I was visiting with some individuals yesterday, but there is going to be a fee for this licensure or whatever it is, isn't there?

SENATOR JOHNSON: Right. And, Senator Cunningham, I think I've got that on my third sheet of paper here. Yes, to do this obviously just like we talked about in Banking Committee or in this committee, that there would be fees that you would charge these people. They estimate that it's $21,000 as I read the fiscal note, but there is a substantial amount of money to implement this program, and that's a concern that I think this committee and all of us need to work out because it's substantial--$96,000 for the first year. But to me this is definitely a step where you're protecting the public's health and I think it's one of the things that we need to seriously consider.

SENATOR JENSEN: On these counterfeit drugs, is it still a worthy drug or are we talking about packaging or are we talking about if I would buy Lipitor and it's counterfeit, it might not have the same ingredients as one at a...?

SENATOR JOHNSON: Yes. Or they will bring in other pills that look like that and mix them, you know, 10 percent of the real thing and 90 percent of the fake ones, or...and I don't know, this probably won't fly in this case but you might remember the...I think it was a pharmacist down in Kansas City dealing with cancer medications where he diluted them out so that they were ineffective. So I think you could probably do it both ways.

SENATOR JENSEN: So some of them are just placebo; there's nothing...

SENATOR JOHNSON: Yes.

SENATOR JENSEN: Thank you. Any other questions? I don't

see any. First testifier in support, please?

KEVIN BORCHER: (Exhibit 2) Good afternoon, senators. My name is Kevin Borcher, B-o-r-c-h-e-r. I am a member of the Board of Pharmacy representing the Board of Pharmacy today. I have a brief statement for you. The Nebraska Board of Pharmacy supports the concept of LB 318. The bill allows for the public health protection by increasing the regulation of wholesaler drug distributors and by reducing the potential for counterfeiting in short or outdated drug distribution. This bill is similar to the model rules for licensure of wholesale drug distributors established by the National Association of Boards of Pharmacy, which the Board of Pharmacy in Nebraska does support. The board does have some concerns. Current statutes allow pharmacies to sell to other pharmacies. The board would not like to change. Hospitals are not always licensed or treated as pharmacies under the current statutes. It is also unclear if the proposed bill will allow hospitals to require a license in order to return drugs back to the distributors. The board feels that an inspection by the wholesale distributors should be required by a third party. The proposed legislation does not address requirements or minimal facility standards for wholesale distributors. Although the current proposed language would require a pedigree for many drugs at risk for counterfeiting, it would exclude a significant number of other drug products. Thank you very much.

SENATOR JENSEN: Thank you. Any questions from the committee? Yes, Senator Byars.

SENATOR BYARS: Yes. I think probably you've answered by questions but you had a couple of reasonable, I think, requests. But, Kevin, you do think tightening the wholesaler licensing in the state of Nebraska is necessary, right?

KEVIN BORCHER: Most definitely.

SENATOR BYARS: Okay, good. Thank you very much.

KEVIN BORCHER: You're welcome.

SENATOR JENSEN: Thank you.

KEVIN BORCHER: Thank you.

SENATOR JENSEN: Any other questions? Thanks for coming forward. Next testifier in support?

KELLY BORYCA: (Exhibit 3) Kelly Boryca representing Pfizer still, B-o-r-y-c-a. Pfizer strongly agrees with the goal of LB 318 which is to ensure patient safety through enhancing the integrity of the distribution system for prescription drugs. For a little background, and Senator Johnson pretty well described it, but about 98 percent of prescription drugs are distributed in a standard pathway. They go from the manufacturer, which would be Pfizer, to a wholesaler; from the wholesaler it goes to a Walgreens, and from a Walgreens, it goes to the patient. It's a straight process. There are three major wholesalers: AmerisourceBergen, McKesson, and Cardinal that do about 90 percent of the business in the United States. So 98 percent of the drugs go through this straight pathway. The concern is that there are a small number of drugs, one to two percent, that don't go through the standard pathway. They will go from Pfizer to a wholesaler, to a secondary wholesaler, to another secondary wholesaler, to a repackager, and then perhaps back to a conventional pharmacy. Those are the wholesalers that this bill would be working to license. And it's interesting to note that Pfizer is the largest drug company in the United States, only distributes our drugs through 40 wholesalers. So we need a very limited number to distribute our drugs. When the drugs are distributed outside of the normal pathway, that's when you look at the 6,000 smaller companies that are out there that are in many cases unlicensed. When we look at this secondary marketplace in light of the sharp rise in counterfeit cases in the U.S., it's increasingly clear that a large number of the secondary wholesalers require some increased oversight. This became very apparent to Pfizer back in April 2003 when a substantial amount of counterfeit Lipitor became available in the mainstream U.S. distribution system. Pfizer and the FDA traced many of these counterfeits back to a secondary wholesaler in Kansas City, and as Senator Johnson mentioned, a repackaging operation in Nebraska. The counterfeiting situation there resulted in three recalls and over

18 million tablets. This means 600,000 prescriptions for one month's supply were sold to patients or were pulled back in time to get them out of their hands. So this is not an imaginary problem; it's a very real problem. It's not just Pfizer drugs. When you look at what is being counterfeited, you'll see versions of important drugs that treat mental illness such as the atypical antipsychotics and antidepressants. You will see AIDS drugs and blood disorder drugs related to cancer treatment and kidney disease. Counterfeiting is a very real problem and the existing regulations have proven ineffective in preventing it. There needs to be greater transparency and tighter controls over the movement of pharmaceuticals in the drug distribution system. The traditional system works when it goes from the manufacturer to the wholesaler to the pharmacy to the patient. It's when you get these sideways and lateral movements that we're seeing problems. When we talk about LB 318, central to that bill is enhanced license requirements for both in and outstate pharmacies. As Senator Johnson mentioned, Nebraska is one of only seven states that have no licensing requirements for outstate pharmacies. I understand that there are legitimate concerns about overregulation, but I really think that this is a hole that needs to be addressed. The bill would also require criminal business background checks. And when I talked to many of these members I handed out an article that talked about the Lipitor counterfeiting situation. And it started with criminals in Florida, where for licensing down there at that time you needed about $100 and a driver's license, so it was very easy for them to get into the business. The bill would also require designation of a facility representative so somebody who knows what they're doing would have to be working at the facility and they would also have to submit a surety bond of at least $100,000. The pedigree information that Senator Johnson shared, pedigrees are simply a road map of where the drug has been. There are two ways to do pedigrees. You can do it with paper where it will go from the manufacturer to the wholesaler to the retailer, and you'd have a list of everywhere it's been; and, again, they're looking at radio tags and we're hoping to have that technology available by the end of 1997...or excuse me, 2007. This bill would require paper pedigrees until the electronic pedigrees are available. The pedigree requirements, there are two of them. One, if the drug

leaves the standard pathway, if it goes from Pfizer to the wholesaler, to the retailer, it wouldn't need a pedigree. It's just when it does that lateral stuff through a number of secondaries. The second place you need a pedigree, the National Association of Boards of Pharmacy has recognized 32 drugs that are very susceptible to counterfeiting. Those 32 drugs would need a pedigree even if they go through the standard pathway. The other thing the bill would do is require criminal penalties. And again, as Senator Johnson mentioned, it has gotten to the point where counterfeiting legitimate pharmaceuticals has penalties that are far less than doing illegal drugs, so that it is an appealing avenue for criminals because they'll get a slap on the wrist versus serious prison time. So the criminal penalties would be increased. That's the bill.

SENATOR JENSEN: Thank you, Kelly. Any questions from the committee? Yes, Senator Cunningham.

SENATOR CUNNINGHAM: Yes, Kelly. You and I talked about licensure costs and I don't see that that's in the fiscal note.

KELLY BORYCA: There's two things...that's a very good question...two things. I've handed out some information on the National Association of Boards of Pharmacy has implemented a verification, a VAWD program, that they would do the actual inspection. And the bill doesn't include a physical inspection, but I agree with the Board of Pharmacy, that would be a great thing to have. The problem is, is it's expensive to send your inspection person to West Virginia to inspect each facility. So this VAWD program through NABP would be a program where they would handle all of the inspections. They would charge the individual wholesaler a fee to get their stamp of approval. They would actually physically inspect, they would do the criminal background checks, everything that the state required. They would charge the wholesaler a fee and they said it would be a sliding fee based on the size of the wholesaler. If you were a small wholesaler, it would probably be close to $1,000. If you were a large wholesaler with multiple sites, it would be $10,000. The difference is, is if you are a small wholesaler, you get the...you pay the $1,000, you get their stamp of approval; you are

legitimate to do business in all 50 states. The larger wholesalers, the McKesson's, the ones that do national business, they would pay $10,000 a year; they would get all of their sites inspected, they would have the criminal background checks, everything that this bill requires. So there would not be a cost to the state if they required the VAWD certification through the National Association of Boards of Pharmacy. I've talked to the licensing people about this and they like it. They said, if we put it in the bill we can't just say NABP; we have to say the VAWD program or something similar because they don't want to just look at one. Currently, there is just one available. The other thing is that Becky pointed out that I did not include any fees in here that if the state chose to do it themselves. She said it would get rid of the current fee for the instate wholesalers. That's where you will see the $21,000 on the fiscal. If you...you could easily put in the bill that a fee would be assessed. It's just that the VAWD program that just became available in November would be a very easy solution for the state to look at which would have national recognition as a verified wholesaler. And also your question about, so they would only charge as much as, a smaller wholesaler would pay less than a larger wholesaler. I also think that if you went with the national program like that, that you could decrease the need for the extra personnel that is pointed out in the fiscal note also.

SENATOR CUNNINGHAM: Okay, thank you, Kelly.

KELLY BORYCA: And your question, Senator Jensen, some of the counterfeits are real. I mean, they have a little bit of the active drug, but some of them have highway paint, and it's very frightening to see what they can put in there, but they'll make it look exactly like a real tablet.

SENATOR JENSEN: Thank you. Any other questions? Thank you for your testimony.

KELLY BORYCA: Thank you.

SENATOR JENSEN: Anyone else wish to testify?

BILL MUELLER: Senator Jensen, members of the committee, my name is Bill Mueller, M-u-e-l-l-e-r. I appear here today on

behalf of the Pharmaceutical Research and Manufacturers of America, PhRMA, in support of LB 318. And we do thank Senator Johnson for bringing the bill. PhRMA certainly supports the licensure of wholesale drug distributors. We intend to speak with the senator and talk to the senator about the definition of wholesale distributor that appears on page 3, lines 10 to 17. And our concern and I think that this is consistent with the Senator's intent to make sure that we don't require a second state license for manufacturers. Manufacturers are licensed and regulated by the Food and Drug Administration, and I'm concerned that the definition of a wholesale distributor in the bill may include manufacturers. I understand that some manufacturers may operate as wholesalers, and my understanding is that if they are operating a wholesalers they would come under this bill. But if a manufacturer is not operating as a wholesaler, they would not have to be licensed again. And I will work with Senator Johnson on that amendment and the members of the committee.

SENATOR JENSEN: Other than that, you support the bill.

BILL MUELLER: Other than that, we do support the bill. We are regulated and we believe that wholesalers should be regulated, as well.

SENATOR JENSEN: Okay. Any questions of Bill? Thank you for your testimony.

BILL MUELLER: Thank you.

SENATOR JENSEN: Next testifier in support, please.

DAVID GONZALES: Thank you, Mr. Chair and members. My name is David Gonzales, G-o-n-z-a-l-e-s. I represent the Healthcare Distribution Management Association which is a national organization of wholesale distributors in strong support of higher licensing standards to address an issue that we're seeing with concern across the country. We, too, have a model bill that looks at the type of licensing standards that have been proposed in this bill. The members of my organization feel like they are a very important part of the prescription drug distribution industry and the entire prescription drug industry because of the part that

they play in distributing the product from the manufacturer to the tens of thousands of retail pharmacy outlets across the country. Our principal responsibility is in the security and the safety and keeping the integrity of these products. It is, in fact, our livelihood and our business. No one was more concerned when we started to hear stories of people outside of our industry trying to breach into this industry to find profit making opportunities to sell an adulterated product. We think that the licensing standards in this bill, as we've seen in model bills across the country, would do a lot for that. In fact, the surety bond issues, the inspection of facilities we think goes a long way. We would also actually add to these licensing standards and even put in a requirement that there be a preinspection of any new licenses so that the questionable people that might consider getting into this industry would think secondly about that with the thought of someone coming to their facility to do a preinspection before licensure was given. One of the issues, quite frankly, that this industry is struggling with is the pedigree. Electronic pedigrees is in the very infant and developing stages of what it is going to be. We don't know exactly when that will be established. The FDA is looking very closely at it. They have had some reports that put it at two or three years, as well. So we're working closely on the federal level but also on a state level. As you can imagine, companies that do interstate commerce across the country are concerned and interested in what the different licensing standards would be across the country and how many different types of licensing standards one company would have to comply with. So we are watching those closely. This bill does, in fact, limit what was referred to as a normal distribution pathway. And for the most part, those numbers were accurate. I would say that 90 percent of all the drug product in this country goes through three or four big wholesalers. Those companies have been doing it for a long time and are experts and consider themselves topnotch in how they address this industry. There are other factions of this industry that would be limited or restricted to a pedigree as laid out in this bill because they fall outside of what is the normal distribution process, which takes me to the paper pedigree requirement. And right now it's hard for those facilities that do hundreds of thousands of units of product a day in distribution from one facility in some areas of the country

to find a way to attach a piece of paper that has the list of chain of custody of that product onto its final destination in those cases where we fall outside the normal distribution. Now, this bill would take that susceptible drug list that was referred to earlier, the list of 32 drugs that this state and every state should pay closer attention to because those are the products that counterfeiters and questionable people who try to enter this industry would go to first. This bill would require a paper pedigree, no matter, regardless of the situation, whether it was normal distribution or not. Those products happen to be the products that are the most highest utilized in this industry to begin with, you can imagine, because they are blockbuster drugs. They do a great job for the people that use them. The economic value or the dollar cost of drugs is high so they're appealing to those people who would get into this market. If we were to attached a paper pedigree to those, even in the normal distribution it would cause somewhat of a slowdown and somewhat of a bottleneck. The facilities that I represent are highly automated. They are paperless, as a matter of fact. Everything is done by bar code. They are all scanned. In fact, the people working the floor have an infrared scanner on their finger that just points at different units and sends them to a corresponding unit on a pharmacy that places an order that day and will the next day and the next day and the next day. So going back to a paper pedigree system in those situations would be problematic. I would ask and have talked to the bill sponsor who is interested in all aspects of this industry that we look at maybe a more transitional step for those susceptible drugs so that we don't...for those wholesalers that are dealing straight manufacturer, wholesale, retail pharmacy, that we don't have to provide the all the paper pedigree requirements that is contained in this bill and that we don't have to struggle with finding a way to attach that piece of paper to a vial, whether it be by rubber band or other means because of the effect that it would have on the efficiencies in this system. We feel like the facilities that are operating aboveboard, the ones that are eager to meet the licensing standards in this bill, there shouldn't be a concern for those types of facilities to the extent that you would someone in what was referred to as the secondary wholesaler market. And we would like to offer to the committee and to the bill sponsor that they consider

maybe a more transitional step for susceptible drugs that's not tied to the strict paper pedigree requirements in this bill and that we fall back. And also I don't have as big a concern for what was referred to as the normal distribution process that this bill also limits. Now there will be some regional wholesalers, some what some people refer to as the secondary market, who fill a valid void. And they've done it for a long time. But they're there because they're in an area of the state or the country that's mostly rural; they deal with more independent pharmacies than maybe your big national chain drugstores. They fill voids in cases where you have a great need for product in one part of the country that doesn't have as much as maybe another part of the country, and it's just...as with any competitive, healthy marketplace, there are secondary wholesalers or wholesalers that fit the speciality needs of what the giant wholesalers would do. And they will be affected to some extent and they'll be asked to put this paper pedigree requirements together. Because of their size, they may be more able to do that because they're not dealing with hundreds of thousands of product a day. I can't necessarily speak specifically for them but I think I would offer that as what their response would be to this committee on this legislation. The only thing I want to end up with is the enforcement standards are very strict and I think they should be because this should be a deterrent to anybody who wants to enter this industry who doesn't know what they're doing. There are two different ways of looking at it in this bill, and one is if you knowingly do this you should be indicted and penalized to the greatest extent of the law. Somebody made mention earlier to the fact that a counterfeit product, in a lot of cases, looks exactly like its original product from its manufacturer of origin. In those cases where a wholesaler happens to have a case or a pallet or some sort of product that enters into the system unknowingly, either through the returns from the pharmacy or something...you just never know. If they don't knowingly know that they have this product that looks identical to what they think they should have and that meets all the requirements that they have met with due diligence in meeting the requirements of this bill, we ask that there be some consideration that they not have the penalties so that you separate people that knowingly do it from those that unsuspectingly fall into that trap.

SENATOR JENSEN: Okay, thank you. David, would this have any effect whatsoever on either foreign companies producing products or Internet sales?

DAVID GONZALES: Your typical wholesaler distributors aren't into the type of Internet pharmacy market that we hear about with importation of drugs, and there is a lot of questions that exist on what the legal parameters are on drugs coming into this country. It wouldn't have any effect on our industry because we are prohibited by law and the FDA from bringing anything that's not FDA approved or working with the manufacturer who is also importing product on an FDA approval basis. We...it's illegal for us to do that today. I think that that's part of the discussion in Washington and even in some states as to what level can they license a wholesaler or a pharmacy in another country to bring what they think would be a secure product in. And I honestly don't...that's not a part of the industry that we are familiar with or represent.

SENATOR JENSEN: Thank you. Any questions of Mr. Gonzales? Thank you for appearing today.

DAVID GONZALES: Thank you.

SENATOR JENSEN: Anyone else wishing to testify in support? Anyone in opposition? Any neutral testimony? Senator Johnson, do you wish to close?

SENATOR JOHNSON: Senator Jensen, members of the committee, I think that one of the things that we got a flavor of of the testimony from...at our hearing today is that there is the definite need that we do something. How the speed and the exact methods that we go about it, we might differ some. But Mr. Gonzales came to my office. He is from out of state, by the way, and has stayed deliberately for our hearing today to work with us. And I see no reason of all of the things, and there are also is a letter from Health and Human Services that actually asks that we delay implementation of this until July 1, 2006. (Exhibit 1) Now, there isn't a whole lot of difference between '06 and '07 as an example of how we might implement the tagging and so on. So I think all of these things can be worked out. I

must tell you that when we first talked about this bill we thought that, well, we would start on it this year. But really the goal would be to finish it next year. But we are having such excellent cooperation and working together. The bill is needed and so I think that we ought to go full speed ahead with these people that are willing to work together and go from there. One last thing, and that is I think it was you, Senator Cunningham, that talked about importation of counterfeit drugs and so on from foreign lands. Actually Canada has a very significant problem this way now that they are getting a lot of counterfeit drugs into Canada with the idea of then repackaging them and selling them to people in the United States over the Internet. So, anyhow, any further questions?

SENATOR JENSEN: Any further questions of Senator Johnson? I don't see any. That will close on LB 318. And with the committee's permission, I will open on LB 381 ad LB 382.

SENATOR ERDMAN: You've got it.

SENATOR BYARS: As you heard, since Senator Jensen has agreed with Senator Jensen, he will introduce both LB 381 and LB 382. Senator Jensen, you'll introduce on behalf of Jensen and Jensen, correct? Thank you, Senator. Welcome to the Health and Human Services Committee.

LB 381 382

SENATOR JENSEN: Thank you, Senator Byars and members of the Health and Human Services Committee. For the record, my name is Jim Jensen, that's spelled J-e-n-s-e-n, representing District 20. And I appear before you today to introduce LB 381. LB 381 was brought to me on behalf of the Lincoln Medical Education Partnership and the bill simply permits the sending of medical orders by facsimile. The bill defines facsimile as, "a copy generated by a system that encodes a document or a photo into electronic signals, transmits those signals over telecommunication lines, and reconstructs the signals to create the exact duplicate of the original document at the receiving end." The bill provides that facsimile medical orders are treated as oral medical orders. I would prefer to direct any specific

questions about the issues to the legislation and the need for fax medical orders and other relating issues to faxing medical orders to those that will follow me. With that, that concludes the opening remarks on LB 381 unless anyone has any questions. I don't see any, Senator Byars.

SENATOR BYARS: No questions? Why don't you proceed onto LB 382.

SENATOR JENSEN: I'll go ahead and open then on LB 382. Again, for the record, my name is Jim Jensen, J-e-n-s-e-n, representing District 20. LB 382 was brought to me by the Nebraska Pharmacists Association which will also follow me in support of this bill. They'll also provide the committee with suggested amendments to the bill. The bill essentially addresses five issues related to prescription drugs in the practice of pharmacy. It provides for electronic imaging prescriptions or facsimile prescriptions and deletes current references to an authorized, transmitted copy of prescriptions. Electronic imaging prescriptions is defined and the bill contains provisions relating to the use of such prescriptions. The bill updates the list of Schedule I controlled substances in Section 28-405 to conform to federal law. It provides for the destruction of solid controlled substances in open unit dose containers or that they have been unaltered...or rather unadulterated...within a longterm care facility or hospital where they were to be administered to residents. They may destroy if witnessed by two members of the healing arts and recorded in accordance with Section 28-411. The bill exempts pharmacist interns from mandatory reporting requirements under Section 71-168. The pharmacist interns are credentialed under the Uniform Licensing Law and are therefore subject to such requirements, but, as students, are not similarly situated to other professions and occupations credentialed under the ULL. It revises the definition of compounding under Section 71-142. As currently defined, compounding means mixing, preparing, or assembling a drug or device. LB 382 defines compounding as the preparation of components into a drug product. And, again, I would prefer that you would ask questions of those that follow me. Certainly this is a method to move towards the new age of electronics and away, again, from the paper pathway that we have in the past. With that, I'll conclude my remarks unless you have any

questions.

SENATOR BYARS: Any questions for Senator Jensen on LB 381 or LB 382? Senator Erdman.

SENATOR ERDMAN: How many pages are there in LB 382, Senator?

SENATOR JENSEN: You know, I don't know. Look in your green copy.

SENATOR ERDMAN: Have you read them all?

SENATOR JENSEN: No, sir, I have not.

SENATOR ERDMAN: Not all 63 pages?

SENATOR JENSEN: No.

SENATOR ERDMAN: Okay. Just checking.

SENATOR BYARS: Thank you, Senator Jensen. Let the record reflect that the National Association of Chain Drug Stores has sent a letter in support of both LB 381 and LB 382. (Exhibit 1) First proponent for LB 381 or LB 382 or both? Welcome.

JOHN TRITT: (Exhibit 2) Good afternoon, and I apologize for my voice. My name is John Tritt and that's spelled T-r-i-t-t. I'm the CEO of Plum Creek Medical Group in Lexington, Nebraska, and I'm also a member of the Nebraska Medical Group Managers Association. I am representing, I guess, every progressive medical practice that has taken on the endeavor to put in electronic records into their practice. I think you've all read and know the government is pushing this endeavor. It's very active in our state. And I can tell you what we experienced is definitely a statewide issue. Approximately a year ago my physicians made the leap to make the investment and put in electronic records into our practice. It went well and I'm proud of what we accomplished. We were about two months into the process and one very small positive option that electronic record presents is an ability to forward an electronic prescription to the pharmacy directly; in our case, directly

from the examining room, as we are wireless completely in our clinic. The strange thing is that it went well. The local pharmacies enjoy it. Our patients loved it. By the time they got to the pharmacy the prescription was there instead of making repeated phone calls back to the clinic asking why the physician hasn't had time to get it to them. Unfortunately, demographics entered into the equation in that a new board member of the Pharmacy Board happens to be one of the pharmacists that we were sending our electronic faxes to. And, quite frankly, it's very simple. The way the laws are written, if you read it very intensely and want to interpret it that way, that we were not meeting completely the letter of that law. So we did voluntarily stop the process. I know that a similar process was going on in North Platte and they also were asked to cease and desist. The only thing I can say as a concern is it's not being universally enforced across the state. And I wish I could start back up tomorrow. I don't why anybody would be against this. It is a more secure environment than we experience today with handwritten prescriptions. It is totally encrypted, password protected, and in a case that a lot of prescriptions are called in now by nursing staff, electronic scripts is actually initiated, in our case, directly by the physician and only he knows the password to the process. The other thing it eliminates is the legibility issue. I have a son who happens to be in med school and I hope we get this taken care of before he enters the profession. (Laughter) But on that note, it is very simple. The technology is here; it exists; it works. And gives us the ability to use it and hopefully position us to take care of some of the financial challenges we all have in healthcare that are coming. Questions?

SENATOR BYARS: Thank you, Mr. Tritt, appreciate it, and I appreciate your testifying on behalf of both LB 381 and LB 382, is that correct?

JOHN TRITT: Yes.

SENATOR BYARS: Any questions? Senator Erdman? Thank you, Mr. Tritt.

JOHN TRITT: I do offer my assistance to the Pharmacy Association to help come to agreement. We've done a little

politicking, if you will, in the back of the room, and I think we can come to a conclusion. Thank you.

SENATOR BYARS: Thank you. Next proponent. Ms. Meeks, good to see you.

HELEN MEEKS: (Exhibit 3) Good afternoon, senators. My name is Helen Meeks. Meeks is spelled M-e-e-k-s, and I'm the administrator of the credentialing division with the Department of Health and Human Services Regulation and Licensure and I'm here to testify in support of LB 381 on behalf of the department. This bill proposes to define facsimile and to create an additional method for a practitioner or his or her agent to transmit a medical order to a pharmacist for filling that medical order. Given today's technology, we agree that prescribers in Nebraska should be able to use technology to support their delivery of better healthcare, including quick, accurate, and secure delivery of prescriptions for medications to pharmacists. Therefore the department supports this legislation and we have four specific reasons that I would like to briefly share with you for our support. First of all is accuracy, and the gentlemen just ahead of me have spoken to that as well as Senator Jensen. Prescriptions can be typed rather than handwritten, thereby reducing the likelihood of preparing and dispensing the wrong medication due to misreading of someone's handwriting. The next reason is efficiency. Prescription medication could be prepared upon receiving the electronic prescription rather than waiting until the customer arrives at the pharmacy with the written prescription, thereby saving the consumer time as well as the prescriber. Would have saved time when the medication was prescribed by inputting the information into the device rather than taking the time to hand write the information. Our third reason is convenience. The expectation of faster and better service is common in today's society on the part of both healthcare providers and patients. And then finally patient safety. Use of devices that provide patient medication profiles or drug interaction information literally at the fingertips of healthcare providers will allow for greater patient safety. We know that there are devices on the market that will provide this information and it will allow the practitioner to then transmit the prescription to the pharmacy using such devices, and this

bill provides authorization for that kind of methodology. While the proposed legislation is intended to change the law to authorize the transmission of medical orders to a pharmacy by a fax so that prescribers may use electronic prescribing devices, we believe that according to a letter received from the Drug Enforcement Administration, commonly referred at the DEA, dated April 8, 2004, the legislation may not fully resolve the issue. The DEA letter indicates that the DEA recognizes facsimile transmission of prescriptions as a valid and acceptable method of communication. The pharmacist has the same obligation to confirm the validity of prescriptions received by facsimile as he or she does on all prescriptions if there are any concerns about the prescription or its validity. DEA's policy is that a facsimile must be an original, written, signed prescription. Given the DEA's position, the department is suggesting that consideration be given to broadening the bill such that a practitioner's authorization for dispensing medication, i.e. a prescription, could be dispensed based on electronically transmitted prescriptions rather than just limiting it to fax. That's one method of transmitting. We believe that broadening the language to include electronic signature in addition to other means of transmission, the DEA requirement for a written, signed prescription could be met. The key issue in the chain of events between the person who prescribes the medication and that information reaching the pharmacy is the ability to authenticate the person who prescribed the medication. We really need to know whether or not that person is indeed authorized by a valid license to prescribe the drug and in the event of controlled substances, whether that person has a valid DEA number that authorizes him or her to do that kind of prescribing. Although a pharmacist always has the discretion to call the person whose name appears on the prescription to verify any of the information on the prescription, an electronic signature on a prescription should be as equally acceptable as obtaining authorization over the telephone for dispensing a medication. The department is very supportive of the concept that is offered by LB 381 but feels the current language could be construed as limiting to only a fax. So, again, we would encourage that thought be given to broadening the concept, and the department is willing to work with the bill's sponsors to achieve this purpose.

SENATOR BYARS: Thank you, Ms. Meeks. Any questions on the part of the committee? Thank you very much.

HELEN MEEKS: Thank you.

SENATOR BYARS: Next proponent testifier for either LB 381 or LB 382 or both? Welcome, Ms. Cuver (pronounced phonetically).

JONI COVER: (Exhibit 4) Hello. I won't say anything. Senator Byars, Senator Jensen, members of the committee, my name is Joni Cover, J-o-n-i C-o-v-e-r, and I am the executive vice president of the Nebraska Pharmacists Association. And on behalf of the members of the Nebraska Pharmacists Association I'd like to offer our support for LB 382 and thank Senator Jensen for his work and for Jeff's work in putting this bill together. LB 382 makes several changes to current pharmacy law. The first thing it does is it adds two hallucinogens to Schedule I to conform with Nebraska law...conform Nebraska law with federal law. And I have been practicing all afternoon on how to say these two names, and I'm not very good at it and I was going to say ditto what Senator Jensen said, but he didn't pronounce them either so. They're in the bill and I'll just let you read those. One of the things we try to do every year is...and if any of you would like to a stab at pronouncing them, please feel free. One of the things we try to do every year when the legislative session occurs is try to make sure that our Nebraska controlled substances mirror what is also scheduled in federal law. So that's just a change. The second provision that LB 382 provides for is updates the definition of compounding. As of January 1, 2005, the United States Pharmacopoeia began enforcing the USP 795 and 797 standards relating to compounding. And the NPA gathered compounding pharmacists from Nebraska to examine the new requirements and compare them with what is currently in our state statute. And just for your information, these new USP standards apply to all compounding personnel. And so in order to reflect these standards, as a starting point our group decided...thank you; I've got...I just asked Sandy Johnson if we knew a good physician or pharmacist that can help me with this frog (laughter); my family has had the flu so I think I've got a bug, too. Anyway,the pharmacists felt

that it was necessary to update the definition of compounding. And so we use the National Association of Board of Pharmacy's compounding definition. And I'd like to say that this is the only change we're going to have to make to our compounding statutes, but currently the USP is under revision with the compounding standards and so I am assuming that we will have more changes to our compounding laws next year, but this is a good start. The next thing that LB 382 does is to exempt pharmacist interns from the mandatory reporting requirements under Section 71-168. Pharmacist interns are pharmacy students that are considered credentialed under the Nebraska law and are the only healthcare professional students subject to the mandatory reporting requirements. Thank you for the water. Pharmacy students receive their registration from the department, I'm assuming within the first 30 days of the beginning of pharmacy school. I know they apply for them and have to be in school ten days before they are allowed to apply, and then the registration shows up within the first 30 days. Our concern with the pharmacist interns being subject to this reporting requirement...and this is particularly in the academic institutions, is that it interferes with the educational process and inhibits the ability of pharmacy instructors to advise students and provide a productive learning environment. The NPA feels that exempting the pharmacy students from the mandatory reporting requirement and treating these students the same as medical students would have a positive impact on the pharmacy profession. And I would be happy to offer some examples of that issue if you would like at another time. And then finally, and what we're all here to talk about today, is the...LB 382 updates and clarifies the language in statute to allow both faxing and electronic transmission of prescriptions. And I want to apologize up front that the language that's currently in LB 382 is not a reflection of what we were trying to accomplish. So forgive me for sending you the long amendment yesterday. You have a current copy of it that the page just handed out, and that's what we would like to see reflected in law. And so let me work from that amendment. One of the...the first thing we did is we went through with the amendment and struck all the electronic image prescription language because that we felt is almost as confusing as the automated transmitted copy language that's currently in statute. We looked at the controlled

substances in federal law, controlled substances statute, and realized that the word "facsimile" appears throughout the Controlled Substances Act. So what we did is we mirror what the federal law says as far as controlled substances. You can fax a prescription and there are the signature requirements listed in those bills. So under the controlled area, Controlled Substances Act, a facsimile is allowed. We're not talking about electronic transmission; we're just talking about allowing a fax prescription. And then depending on which control...if it's a II, III, IV, or V, what the signature requirement is, what constitutes an emergency, and that sort of thing. So those are all defined in the statute. And then what we do is we look at the Pharmacy Practice Act and we allow for a facsimile and electronic transmission of prescriptions, and both of those terms are defined in the amendment. We have also made allowances for unsigned faxes and electronic transmission of prescriptions to be treated as oral medical orders. That way if it comes over the fax, it comes through the computer. A pharmacist can look at the information and can verify if they need to and use their professional judgment. We've also gone through and listed what is required for an electronic transmission and what is required for a fax to transmission of a prescription. There is some debate on whether or not you have an oral prescription and a written prescription and an electronic to print transmitted prescription and a fax prescription, or if you just have oral and written, and the fax and the electronic transmission are a means of getting them from one place to the other. I'll let you all debate that because I could tell you that practitioners don't actually agree on that either. What the goal of this legislation was is to allow prescribing practitioners to fax or electronically transmit prescriptions to pharmacies. And I realize that there is a lot of verbiage in this amendment. We started out with just some simple language, and you know how it is when you start changing one statute; it leads to another and leads to another. And that's the result of the 63-page bill; thank you for pointing that out. I cannot begin to tell you the number of calls that I have received from frustrated physicians, not pharmacist but physicians, that have purchased software programs in Nebraska to later find out that they can't use them. And so just as a personal point of privilege I would like to have them stop calling me, so

please pass this bill. (Laughter) In addition, and I've provided this to you, the Nebraska Board of Pharmacy sent out a letter talking about faxing prescriptions and then what is required of the electronic transmission. And so that's kind of how this all started. And so I've provided that for your information, as well. And John, Mr. Tritt, said in his testimony that depending on where you live in the state of Nebraska is how the law is being interpreted. I wish I could say that wasn't true, but it is true. So a little education on this whole issue once we get it to fruition it would be a good idea, as well. I would like to thank the Medical Association, the Lincoln Medical Foundation, the Board of Pharmacy, WebMD, the department, Senator Jensen's office, and all the others who have been involved in this. We all agree that this a problem. We all agree that this needs a solution. We are offering two different ways to solve it. We're not sure what is the best way; we're not sure that it's all inclusive. We're looking to you to help us with this issue but we do think that it's an important issue that needs to be taken care of as soon as possible. I'd also like to say that we're supportive of LB 381, and it does recognize the validity of fax prescriptions. I'm just afraid that if we just take LB 381 language, we still won't be able to use the computer programs to fax. And maybe your interpretation is different. And if that's the solution that you would like to see, that's great. We just wanted to take a broader approach and make sure that more things, the technology, was covered under our recommendation. So with that, if you have any questions I would try to answer them.

SENATOR BYARS: Thank you, Ms. Cover. Appreciate you being here. Next time you can transmit your disease to us electronically. (Laughter) Any other questions? Dr. Johnson? I mean, Senator Johnson.

SENATOR JOHNSON: Well, not really a question but a comment. I think it's very important that you look to the future as far as communications is concerned. So I think to cut it down to just one thing is definitely a mistake and that I think you ought to have broad language for what is usable. And then the other thing is this: You talked about defining emergency and this sort of thing as when this could be used. Is there anything wrong with just becoming efficient?

JONI COVER: Certainly not.

SENATOR JOHNSON: Thanks.

SENATOR BYARS: Thank you, Senator.

JONI COVER: I just have one comment, with the...we would like to see electronic transmission for controls, as well, but we have been told that the DEA won't allow us to do that. I know that other states are currently venturing down that path, but so far I haven't found anyone that's real comfortable, other than me, venturing down that path right now. So, again, we're just containing the controlled substances to faxes, which is allowed under federal law, it's in the federal law, and then the rest of the drugs can be sent electronically, you can electronically transmit them.

SENATOR BYARS: Thank you, Ms. Cover. Any other questions? Senator Jensen.

SENATOR JENSEN: Yes, if I may. If we get all this worked out...

JONI COVER: Yes.

SENATOR JENSEN: ...and there isn't on the bill, I think perhaps an E clause ought to be added to alleviate some of this.

JONI COVER: I would agree.

SENATOR JENSEN: It's not on there. And then the other thing, you know, we're not all that far away from voice activated emails, and I don't know if we want to go into that now, but there is...we're I would say no more than two years away from that where we won't have to use our fingers anymore.

JONI COVER: We are going to see with the Medicare Modernization Act some changes. I know you don't like to hear that, but we're going to see changes in electronic prescribing and electronic records. What it's going to look

like, I don't know. We've been waiting for the DEA to come out with electronic prescribing for years. And I just think that it's important for patients and providers in the state of Nebraska to bring our state statute up to at least to do what we are allowed to do under federal law and to allow these great practitioners who have this software that can improve patient safety to send it to the pharmacists. It's going to cut down on work on both sides. It's going to make patients safer, fewer medication errors. And I just...and if you would like to work on voice activated email or whatever, I would be happy to oversee the comments after it's drafted. (Laugh)

SENATOR BYARS: Thank you very much. Any other questions of Ms. Cover? If not, thank you very much. Next proponent for LB 381 or LB 382 or both?

DAVID FILIPI: Good afternoon. I'm Dr. David Filipi, F-i-l-i-p-i, of Omaha. I'm here to support both bills. I am president of the Metropolitan Omaha Medical Society and my real job is being vice president of medical affairs for a 140-doctor group in Omaha. I'm not going to repeat the previous testimony. I support it all. Our 140 doctors particularly support it all. They asked me to come here today because we're implementing an electronic medical records system that we want to make their lives more efficient and to have our patients to be more safe, both in more legible prescriptions and also in terms of having the logic behind it to make sure that we don't have contraindications built in to the prescription, allergies, that type of thing, so that we have a safer environment for patients. Electronic medical records are not inexpensive. They may cost up to $30,000 per physician to start doing it. So we need to develop some efficiencies in our systems as we go forward. One of the big efficiencies is not having to sit down, write a prescription down, having a nurse phone it it, give it to the patient that may or may not have the prescription filled, may lose the prescription, that type of thing. So I support the expanded language of faxing or electronic prescription which our software should be able to do.

SENATOR BYARS: Thank you, Dr. Filipi. Any questions? Thank you very much for being here.

DAVID FILIPI: Thank you.

SENATOR BYARS: Any other proponents of LB 381, LB 382, or both? How many more testifiers do we have in favor? Okay. I will ask everyone to keep your testimony as brief as possible and not be redundant and so we can conclude for the afternoon. Thank you. Mr. Keetle.

ROGER KEETLE: (Exhibit 5) Good afternoon. For the record my name is Roger, R-o-g-e-r, Keetle, K-e-e-t-l-e. I'm the registered lobbyist for the Nebraska Hospital Association and we're here to support LB 381. LB 382 or LB 383 is on our monitor list. I have not seen the pharmacist amendment yet and would really...I know Joni and I have both been busy on separate issues so we just haven't crossed paths, but I definitely want to look at that. And would be willing to send that to an outside attorney to be reviewed on kind of the other aspects of it, so I've got a good legal counsel that's in this area that would be, should be involved. With that, I won't repeat the other testimony. I won't...this is an excellent bill; it needs to done. The other issue we've got to deal with is making all these systems compatible. There is a meeting Friday in Kearney that talks about that, so we've got a lot of things to do and that's why it's very important the language be crafted very carefully. So with that I'd take any questions.

SENATOR BYARS: Thank you, Mr. Keetle. Any questions of the committee? If not, thank you. Next proponent testifier, please.

NICK WILLARD: Good afternoon, Senator Byars, members of the committee. My name is Nick Willard, W-i-l-l-a-r-d. I'm a consultant to the WebMD Corporation and I live in Alexandria, Virginia. I'm very pleased to be here today to present WebMD's views on this bill. We have worked very closely with Joni Cover and the Pharmacists Association on her amendments. Currently WebMD supports about 185,000 physicians nationally. We are the leading provider of physician management software in the country. And our physicians are now transmitting close to 200,000 prescriptions a month electronically. through our system. We're very, very interested in having this bill

become law and we would ask you to advance the bill to the General File. Thank you very much.

SENATOR BYARS: Thank you, Mr. Willard. Appreciate it. Any questions of Mr. Willard? He's gone.

NICK WILLARD: Excuse me. I understood your timing.

SENATOR BYARS: You listen very good. Next proponent.

KEVIN BORCHER: (Exhibit 6) Good afternoon. My name is Kevin Borcher, B-o-r-c-h-e-r, a pharmacist from Omaha, and I'm representing the Board of Pharmacy. In the interest of the committee's time, I'm not going to reiterate what everyone else has said. I just want to say that the Nebraska Board of Pharmacy does support the concepts of electronic prescribing and allow electronic signatures to reduce handwriting errors. These bills do not solve everything but they're a good start. The one comment I do want to make is that the board has not voted to endorse the language to exempt pharmacist interns from the uniform licensing laws at this time as proposed in 71-168. Thank you very much.

SENATOR BYARS: Thank you very much. Any questions? Thank you.

KEVIN BORCHERS: Thank you.

SENATOR BYARS: Appreciate your testimony. Next proponent and last proponent, I think. Welcome.

SANDY JOHNSON: (Exhibit 7) Thank you, senators. My name is Sandy Johnson. I'm executive vice president of the Nebraska Medical Association, S-a-n-d-y J-o-h-n-s-o-n. I'm really delivering this message from Dr. Michelle Petersen, M-i-c-h-e-l-l-e P-e-t-e-r-s-o-n, who is a pediatrician here in Omaha on behalf of the Nebraska Medical Association. What I would add from here testimony is that patient safety is improved by prescribing electronically. It also accounts for variation in weight and body mass for children when you are working with this on the computer. Allergies and medication interactions can be immediately assessed and modifications done at the time of the visit. Names of

medications, dosages, medication strengths are legible. This decreases the risk of medical errors, which is one reason why this needs to be fixed so we can do this in Nebraska. It helps avoid fraud, errors. Also she discussed prescription pads. They can be stolen. It's much hard to take and steal a computer. It requires a considerable amount of sophistication to go in and alter it, and there are all kinds of safety features that have been put in these computer programs so you have to have passwords, and so on, so that they are protected and they are safe to use. I will tell you, as Joni said, she received a lot of calls from physicians. So did I, and when they called me I just told them to call Joni. (Laughter) I will also say in visiting with my counterparts from across the country, I don't think other states are having the same problems that we have probably seen with this one. I haven't found any other state. So I thank you for trying to work with us to help us fix this.

SENATOR BYARS: Thank you, Ms. Johnson. Any questions from the committee? Thank you very much. Any other proponents of LB 381 or LB 382? Anyone to testify neutral? Anyone testifying against? If not, this closes the hearing on LB 381...would you like to close, Senator? Senator Jensen and Jensen waives closing.